BEAUMONT INFUSION CENTERS

NEUROLOGY PRESCRIPTION

Location / ☐ **Royal Oak : 248- 551-3168** ☐ **Troy : 248-964-2409** ☐ **Lenox : 947-523-4061** ☐ **Wayne : 734-467-2505**
Fax Number ☐ **Grosse Pointe : 586-498-4497** ☐ **Farmington Hills : 248-471-8217** ☐ **Dearborn : 313-593-8551** ☐ **Livonia : 734-542-3356**

Patient Name:	**Date of Birth:**	**Medical Record #:**
Physician Name:	**Physician Address:**	**Physician Office #:**
Diagnosis:	**Diagnosis Code (ICD-10):**	

Please attach these *required* documents to Prescription (if not in EPIC):
● Copy of Insurance Card ● Labs ● Supporting clinical documentation ● Patient Demographics
☐ **NKDA** ☐ **Drug Allergies:**_____
Height: _____ **Weight:** _____ **kg/lbs** **Date:** _____

Ocrelizumab: Hepatitis B screening completed and patient is clear to receive treatment ☐ **Yes** ☐ **No**

CBC w/ Diff, UA, TSH, Serum Creatinine REQUIRED within One Month of Infusion for Alemtuzumab (Lemtrada)

MEDICATION	DOSE	# Doses
ALEMTUZUMAB (LEMTRADA)	☐ **Cycle One:** 12 mg in 100 mL NS to infuse daily IV over 4 hours for 5 days ☐ **Cycle Two:** 12 mg in 100 mL NS to infuse daily IV over 4 hours for 3 days **Pre Medications:** • Diphenhydramine 50mg IVP daily ½ hour prior to infusion. • Methylprednisolone 1000 mg IV over one hour prior to infusion for first 3 days of treatment ☐ Methylprednisolone 500 mg IV over ½ hour prior to infusion on Day 4 of treatment ☐ Methylprednisolone 250 mg IV over ½ hour prior to infusion on Day 5 of treatment ☐ Loratadine 10 mg PO daily prior to each infusion. ☐ Famotidine 20 mg IV push daily prior to each infusion. ☐ Acetaminophen 1000 mg PO ½ hour prior to each infusion. **Other Meds During Infusion:** ☐ Acetaminophen 1000 mg PO q4h PRN for flushing ☐ Ibuprofen 600mg PO q6h PRN for pyrexia, headache (alternate with acetaminophen) ☐ Diphenhydramine 25 mg IV push q6h PRN for minor itching, or rash ☐ Ondansetron 8 mg PO q4h PRN for nausea	
METHYLPREDNISOLONE (SOLUMEDROL)	☐ 250mg OR ☐ 500mg over 30 minutes ☐ 1gm OR ☐ 2 gm over one hour IV every 24 hours x _____ Days	
NATALIZUMAB (TYSABRI)	☐ 300 mg in 100 ml NS over 60 minutes IV every 28 days (monthly). For the first 12 doses observe for one hour post infusion.	
OCRELIZUMAB (OCREVUS)	☐ **Initial Dosing:** 300 mg in 250 ml NS IV infusion every two weeks x 2 doses Start infusion at 30 ml/hr. Increase by 30 ml/hr every 30 minutes up to a maximum of 180 ml/hr. ☐ **Maintenance Dosing:** 600 mg in 500 ml NS IV infusion every 6 months for 1 year (To start 6 months from initial first dose) Start infusion at 40 ml/hr. Increase by 40 ml/hr every 30 minutes up to a maximum of 200 ml/hr. If no previous serious infusion reactions infusion can start at 100 mL/hr for the first 15 minutes; increase to 200 mL/hr for the next 15 minutes; increase to 250 mL/hr for the next 30 minutes; increase to 300 mL/hr for the remaining 60 minutes. **Pre Medications:** • Diphenhydramine 50mg IVP daily ½ hour prior to infusion. • Methylprednisolone 100 mg IV ½ hour prior to infusion. ☐ Acetaminophen 650 mg PO ½ hour prior to infusion. • Observation for at least one hour after the completion of the infusion.	
	• 250 ml 0.9% Sodium Chloride flush bag with infusion as needed. • Adult Anaphylaxis Protocol. Notify physician if reaction occurs.	

Physician Signature _____**Beeper #**_____ **Date** _____ **Time** _____