Ocrevus

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, Negative Hep B Result

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal ☐ Home Infusion

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ G35 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI

☑ Negative Hepatitis B Test (list results/date & attach clinicals):

_____

Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Ocrevus induction.

☐ I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals)

_____

PRE-MEDICATION ORDERS

It is recommended to pre-medicate with Methylprednisolone or an equivalent corticosteroid and an antihistamine (e.g. Diphenhydramine) approximately 30-60 minutes prior to each infusion.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Methylprednisolone ☐ 40mg / ☐ 125mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

☑ Quantitative Serum Immunoglobulin ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other: _____ ☐ Frequency: _____

☐ Urine Pregnancy ☐ at each dose ☐ every _____

☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

☑ Ocrevus Intravenious infusion

☐ Loading:
Dose: 300mg in 250mL 0.9% Sodium Chloride
☐ Frequency: on Day 1 and Day 15

☐ Maintenance:
Dose: 600mg in 500mL 0.9% Sodium Chloride
☐ Frequency: 6 months from Day 1 Loading Dose and every 6 months thereafter

☐ Monitor patient for one hour after completion of infusion

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) | Provider Signature | Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***