Ocrevus
(Ocrelizumab)

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Insurance Information, All Clinical Documentation Supporting the Diagnosis, Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing, Recent Labs Including Hep B Results and Serum Immunoglobulins.

PATIENT INFORMATION

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

Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ G35.A ☐ G35.B1 ☐ G35.B2 ☐ G35.C1 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
- ☑ Hep B (HBsAb and anti-HBc) Test Results (list & attach clinicals):

  _____
- ☑ Serum Immunoglobulins (list results & 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

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Ig Panel ☐ at each dose ☐ every _____
- ☐ Urine Pregnancy ☐ at each dose ☐ every _____
- ☐ Other: _____ ☐ Frequency: _____
- ☐ 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 Intravenous infusion
- ☐ **Initial Dose:** 300mg on Day 1 and 300mg on Day 15
- ☐ **Maintenance Dose:** 600mg every 6 months (starting 6 months from Day 1 and then 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.***