

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, Serum Immunoglobulins, Liver Function Tests

PATIENT INFORMATION

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

Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): ☐ G35.A ☐ G35.B0 ☐ G35.B1 ☐ G35.B2 ☐ G35.C0 ☐ G35.C1 ☐ G35.D 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

- ☒ Deliver patient care in accordance with Infusion for Health clinical procedures and the medication's prescribing information (PI), including management of hypersensitivity reactions
- ☒ Hep B Results (HBsAg and anti-HBc)
- ☒ Serum Immunoglobulins Results
- ☒ Liver Function Test Results (ALT, AST, Alkaline Phosphatase, Bilirubin)

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.

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: _____

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)
- ☒ 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.

SPECIAL INSTRUCTIONS:

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.