Ocrevus referral form

Infusion Pharmacy Phone: Fax:

✂ Please detach before submitting to a pharmacy - tear here.

Care specialist Name: Phone:

Patient information ☐ see attached

Patient name: Gender: ○ M ○ F DOB: Last 4 of SSN:

Address: City: State: ZIP:

Phone: Cell:

Emergency contact: Phone: Relationship:

Insurance ☐ Front and back of insurance cards to follow

Primary Insurance: Phone: Policy #: Group:

Secondary Insurance: Phone: Policy #: Group:

Primary diagnosis ICD-10 code Diagnosis: ☐ Primary progressive ☐ Active Secondary Progressive ☐ Isolated Syndrome ☐ Relapsing remitting

Medical assessment Height: Weight: ○ lbs ○ kg

Current medications? ○ Yes ○ No If yes, list or attach:

Allergies:

Prescription and orders

Ocrevus, x1 year infused per the drug PI recommended rate and via rate controlled device per therapy

☐ Initial Dose 1: 300mg in 0.9% Sodium Chloride 250ml IV infused over approximately 2.5 hours or longer. Date needed:

☐ Initial Dose 2: 300mg in 0.9% Sodium Chloride 250ml IV infused over approximately 2.5 hours or longer. Date needed:

Subsequent Doses (select one):

☐ 600mg in 0.9% Sodium Chloride 500ml IV once every 6 months infused over approximately 3.5 hours or longer.
Date Needed:

☐ 600mg in 0.9% Sodium Chloride 500ml IV once every 6 months infused over approximately 2 hours or longer as tolerated (for patients with no prior serious infusion reactions with any previous Ocrevus infusion). Date Needed:

Pre-medications, x1 year Administer 30 minutes prior to infusion

☐ Methylprednisolone 100 mg (or an equivalent corticosteroid) administered intravenously

☐ Acetaminophen PO ○ 325 mg ○ 650 mg ○ mg | ☐ DiphenhydrAMINE PO ○ 25 mg ○ 50 mg ○ mg

☐ Other:

Nursing orders, x1 year:
Nursing to administer prescribed medication and establish and/or maintain IV access. IV access to be flushed by nurse:

- Sodium Chloride 0.9%: 5mls pre-infusion and 5mls post infusion
- If port access: Sodium Chloride 0.9%, 10mls pre-infusion and 10mls post-infusion followed by Heparin 100 units/ml, 5mls as final lock for patency

Pharmacy orders, x1 year
Pharmacy to dispense flushes, needles, syringes and HME/DME quantity sufficient to complete therapy as prescribed

☑ **Anaphylaxis Kit Order** Infusion Reaction Management x1 year

Mild	• Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated. ☐ DiphenhydrAMINE PO ○ 25mg ○ 50mg ○ mg Dispense diphenhydrAMINE 25mg capsules x 4
Moderate	• Stop Infusion, resume at 50% rate when symptoms resolve ☐ DiphenhydrAMINE IV ○ 25mg ○ 50mg ○ mg Dispense diphenhydrAMINE 50mg vial x 1
Severe (Anaphylaxis) ***Call 911*** **Notify prescribing physician**	• Stop infusion and remove tubing from access device to prevent further administration • Initiate 0.9% NaCl 500ml/hr IV OR ml/hr • **Administer EPINEPHrine 1mg/ml by weight (Wt.) as an IM injection into the lateral thigh** Wt > 66lbs (30kg) 0.3mg/0.3ml; Wt 33 to 66 lbs (15 to 30kg) 0.15mg/0.15ml; Wt < 33lbs (15kg) 0.01mg/kg • Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrive ☐ Dispense 0.9% NaCl 500ml x1 ☐ Dispense EPINEPHrine 1 mg vial x 2 ☐ Other medication:

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Patient name: DOB:

Physician information

Name: Practice:

Address: City: State: ZIP:

Phone: Fax: NPI: Contact:

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible signature | Dispense as written signature | Date

Please fax: ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and labs
☐ Hepatitis B Screening and serum Ig test results

Please include ALL pages when faxing