

Ocrevus

(Ocrelizumab)

Treatment Location: Dublin, OH Lancaster, OH

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.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 Infuse One Ohio
- Hep B (HBsAb and anti-HBc) Test Results (list & attach clinicals): _____
- Serum Immunoglobulins (list results & attach clinicals) _____
- Liver Function (ALT, AST, Alkaline Phosphatase, Bilirubin) Test Results (list results and attach clinicals) _____

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, Infuse One Ohio is authorized to administer a generic or biosimilar.

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: _____

Provider Name (Print) _____ Provider Signature _____ Date _____

- Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.