Ocrevus referral form

Phone: 1-877-342-9352
Fax: 1-888-594-4844

PATIENT INFORMATION

Acute care specialist: Name	**Phone:**	**Patient:** ☐ see attached Gender: ☐ Male ☐ Female	
Patient name:		DOB:	SSN:
Address:			City:
State:	ZIP:	Phone:	Cell:
Emergency contact:		Phone:	Relationship:
Insurance: ☐ Front and back of insurance card to follow			
Primary Insurance:	Phone:	Policy #:	Group:
Secondary Insurance:	Phone:	Policy #:	Group:

Primary diagnosis: ☐ Relapsing Forms of Multiple Sclerosis (MS): ☐ Isolated Syndrome ☐ Relapsing Remitting ☐ Active Secondary Progressive ☐ Primary Progressive

Medical assessment: Height: Weight: ☐ lbs ☐ kg

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

Allergies:

PRESCRIPTION ORDERS Ocrevus, x1 year infused per PI recommended rate and via rate controlled device per therapy

☐ Initial Dose 1: 300mg in 0.9% Sodium Chloride 250mL IV Date needed:
☐ Initial Dose 2: 300mg in 0.9% Sodium Chloride 250mL IV Date needed:
☐ Subsequent Doses: 600mg in 0.9% Sodium Chloride 500mL IV once every 6 months. 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 arrives ☐ Dispense 0.9% NaCl 500mL x1 ☐ Dispense EPINEPHrine 1 mg vial x 2 ☐ Other medication:

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:	Date	Dispense as written Signature:

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