Ocrevus referral form

Optum 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:

This form is not a valid prescription in Arizona.

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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

This form is not a valid prescription in Arizona.

