Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Ocrevus® (ocrelizumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight: LB or KG	Gender:	Allergies: ☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	G35 - Relapsing Remitting Multiple Sclerosis
☐	G35 - Primary Progressive Multiple Sclerosis
☐	_____- Other:

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Quantitative Serum Immunoglobulin screening
6	**REQUIRED**: **HBsAg, anti-HBc, and anti-HBs**

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive ocrelizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new onset or deterioration neurological changes, and/or surgery.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*Per FDA labeling, Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion

IV	Diphenhydramine	☐	25mg	☐	50mg		
	Methylprednisolone	☐	40mg	☐	125mg	☐	Other:
	Famotidine	☐	20mg	☐	40 mg		
	Other:	☐					

PO	Acetaminophen	☐	325mg	☐	500mg	☐	650mg	☐	1000mg
	Famotidine	☐	20mg	☐	40mg				
	Diphenhydramine	☐	25mg	☐	50mg				
	Fexofenadine	☐	60mg	☐	180mg				
	Cetirizine	☐	10mg						
	Loratadine	☐	10mg						
	Other:	☐							

MEDICATION/FREQUENCY:

☐ Induction: Ocrevus® 300mg IV in 250ml NS to be infused over 2.5 hours or longer per step protocol at week 0 and 2 weeks

☐ Maintenance: Ocrevus® 600mg IV in 500ml NS every 6 months

Follow each infusion with a (1) one-hour post observation period.

SPECIAL/LAB ORDERS:

☐ _____

_____

MAINTENANCE INFUSION TIME:

☐ Infuse maintenance dose over 2 hours per step protocol

☐ Infuse maintenance dose over 3.5 - 4 hours per step protocol

Prescriber to monitor patient for symptoms of HBV infection and reactivation as clinically appropriate.

☑ Refills x 12 months unless noted otherwise here:

***Maintenance dosing is scheduled 6 months from initial 0-week dosing.**

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	