medix infusion

Ocrevus® Order Form
(ocrelizumab)

FAX TO: 866.746.3890

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

Diagnosis

ICD 10 Code

☐ G35.A Relapsing-Remitting Multiple Sclerosis
☐ G35.B0 Primary Progressive Multiple Sclerosis, Unspecified
☐ G35.B1 Active Primary Progressive Multiple Sclerosis
☐ G35.B2 Non-active Primary Progressive Multiple Sclerosis
☐ G35.C0 Secondary Progressive Multiple Sclerosis, Unspecified
☐ G35.C1 Active Secondary Progressive Multiple Sclerosis
☐ G35.D Multiple Scelrosis, Unspecified
☐ Other: _____

Infusion Orders

DIRECTIONS/DURATION

Ocrevus® (ocrelizumab)

☐ **INITIAL DOSE:** 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x 1 year
☐ **MAINTENANCE DOSE:** 600mg IV every 6 months x 1 year

Ocrevus Zunovo® (ocrelizumab/hyaluronidase)

☐ 23 mL (ocrelizumab 920mg and hyaluronidase 23,000 units subcutaneously in the abdomen every 6 months x 1 year)

☐ Inject SC in the abdomen over 10 minutes every 6 months x 1 year
Observe patient for 1 hour after initial dose and for 15 minutes post-injection for all subsequent doses

PRE-MEDICATION ORDERS

Ocrevus (ocrelizumab)

☐ Methylprednisolone 100 mg IV (or equivalent corticosteroid) administered intravenously approproximately 30 minutes prior to each infusion
☐ Diphenhydramine 25mg PO or IV
☐ Diphenhydramine 50mg PO or IV (may substitute antihistamine with: Loratadine 10mg PO, or Cetrizine 10mg PO or IV) 30 minutes prior to infusion
☐ Acetaminophen 650mg PO (optional) 30 minutes prior to infusion

Observe patient for 1 hour after completion of infusion

Ocrevus Zunovo (ocrelizumab/hyaluronidase)

☐ Dexamethasone 20mg PO (or equivalent corticosteroid)
☐ Diphenhydramine 25mg PO (or equivalent antihistamine)
☐ Diphenhydramine 50mg PO (or equivalent antihistamine) 30minutes prior to infusion

Observe patient for 1 hour initial dose and 15 mins subsequent dose

LAB ORDERS

Labs to be drawn by: ☐ Medix Infusion ☐ Referring Physician
☐ Hepattits B virus (HBV) screening (HBsAg, Hepatitis B core antibody)
☐ Quantitative serum immunoglobulins (IgG, IgM, and IgA)
☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____
☐ ESR q _____ ☐ LFTs q _____ ☐ Other _____

Required Clinical Documentation

☐ Include patient's medication list
☐ Include signed and completed order (MD|prescriber to complete)
☐ Include patient demographic information and insurance information
☐ Include labs and|or test results to support diagnosis
☐ Supporting clinical notes to include any past tried and|or failed therapies, intolerance, benefits, or contraindications to therapy
  ☐ Expanded Disability Status Scale (EDSS) score: _____
☐ If applicable - Last known biological therapy: _____ and last date received: _____ . If patient is switching biologic therapies, please perform a wash-out period _____ weeks prior to starting Ocrevus®.
☐ Other medical necessity: _____
☐ Quantitative serum immunoglobulins testing (IgG, IgM, and IgA) prior to first dose
☐ **Hepatitis B screening test completed including Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - attach results**
  ☐ **Positive** ☐ **Negative** **If Hepatitis B results are positive - please provide documentation of treatment or medical clearance**

Referring Physician Information

Prescriber Name: _____ Signature: _____ Date: _____

NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____