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: _____

Medication Order

	DIRECTIONS/DURATION	
Ocrevus® (ocrelizumab)	☐ 300 mg IV at 0 and 2 weeks, then 600 mg every 6 months ☐ 600 mg IV every 6 months **Pre-Medication Orders** Methylprednisolone 100mg IV and Diphenydramine 25 mg PO/IV **Additional Pre-Meds:** ☐ Tylenol 650 mg PO ☐ Zofran 4 mg PO ☐ Famotidine 20 mg PO ☐ Ceterizine 10 mg PO	☐ x 1 year ☐ _____
Ocrevus/Zunovo® (ocrelizumab/ hyaluronidase	☐ 920 mg/23,000 units subcutaneously every 6 months **Pre-Medication Orders** Dexamethasone 20 mg PO and Diphenydramine 25 mg PO **Additional Pre-Meds:** ☐ Tylenol 650 mg PO ☐ Zofran 4 mg PO ☐ Famotidine 20 mg PO ☐ Ceterizine10 mg PO	☐ x 1 year ☐ _____

Lab Orders
Requested Add'l Lab Orders:
_____
_____

Lab Frequency: _____every _____weeks

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

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose:
_____

☐ 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**

Medix Infusion will collect all necessary labs if not included in referral documents

Referring Physician Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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