

Ocrevus (ocrelizumab) | Order Form

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

- Copy of insurance card Patient demographics History & physical
- Labs; including quantitative serum immunoglobulins and HBV (may include HCV, HIV, TB if indicated based on patient risk factors)

2. Patient Information

Male Female Height: _____ in/cm Weight: _____ lbs/kg NKDA Allergies: _____
 Is this the first dose? Yes No, date of last infusion: _____ Next due: _____ Line type: PIV PICC Port Other

3. Diagnosis and Clinical Information

ICD-10 (required): _____ Primary diagnosis: Multiple sclerosis _____ Other: _____

4. Prescription Information

Medication	Ocrevus 300 mg (30 mg/mL) single-dose vial(s)
Dose / Frequency	<input type="checkbox"/> Initial and maintenance dosing: Ocrevus 300 mg IV on days 1 and 15, then 600 mg every 6 months <input type="checkbox"/> Maintenance dosing only (initial dosing already complete): Ocrevus 600 mg IV every 6 months <input type="checkbox"/> Other: _____
Directions	<input checked="" type="checkbox"/> Dilute per manufacturer guidelines in compatible IV fluid. Administer the diluted solution using a 0.2 or 0.22 micron in-line filter, infused per protocol based on dose and tolerability. <input type="checkbox"/> Other: _____
Quantity / Refills	<input checked="" type="checkbox"/> Dispense QS on all selected medications / Refill x 12 months <input type="checkbox"/> Other: _____ _____ Dispense all medical supplies necessary for infusion

5. Additional Orders

- RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per PromptCare Policy and Procedure

Premedications: Give standard premedications 30 min prior to infusions

- Diphenhydramine 25-50 mg PO, indicate if IV required: give slow IV push (over 2-3 min as tolerated)
- Methylprednisolone 100 mg slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)
- Acetaminophen 325-650 mg PO
- Other: _____

RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.

RN to monitor patient for at least 1 hour post infusion and educate on possible side effects, allergic reactions, and when to contact physician

6. Adverse Reaction Orders

Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 License No.: _____ DEA NO.: _____ NPI: _____

Physician Signature (Substitution Permitted)

 Date

Physician Signature (Dispense as Written)

 Date