OCREVUS® (OCRELIZUMAB) PRESCRIBER ORDER FORM

*****Please fax all pages with a copy of medical history and recent labs to (888) 388-1309*******
For Inquiries call: **Georgia** prescribers line: **(844) 803-2220** **All other** prescribers:**(844) 598-2557**

Patient Information

Date of Birth:	Patient name:	☐ Male ☐ Female
Requested Start of Care Date:	Height:	Weight (kg):
Address:	City: State:	Zip:
Allergies:		

Clinical Information

Primary Diagnosis Description:_____	ICD-10 Code:_____
Hepatitis B Status ☐ Positive ☐ Negative Titer Date: _____ (Please include documented results of surface antigen and core antibody)	Quantitative Serum IG:_____

Ocrelizumab (Ocrevus) 300 mg/10 mL Prescription

Initial Dose: ☐ Infuse 300 mg IV over at least 2.5 hours on Week 0 and 2. Dispense #2 vials

☐ Other: _____

Maintenance Dose: ☐ Infuse 600 mg IV over at least 2 hours every 6 months. Dispense #2 vials Refill as directed x 1 year.

☐ Infuse 600 mg IV over at least 3.5 hours every 6 months. Dispense #2 vials Refill as directed x 1 year.

☐ Other: _____

If planned maintenance dose is missed, administer dose ASAP and reset dosing schedule to six months after the missed dose was administered. Maintenance doses must be separated by at least 5 months.

Ancillary and Premedication Orders / Other Orders- Dispense PRN X 1 year

☐ **Anaphylaxis Kit**

- Diphenhydramine Tab Administer 50 mg PO x1. May repeat once if symptoms persist.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN if no improvement.
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours

Pre-Medication Orders

☐ Methylprednisolone sodium succinate _____ mg IV 30 min prior to infusion.

☐ Diphenhydramine _____ mg PO 30 min before infusion.

☐ Acetaminophen _____ mg PO 30 min before infusion.

☐ Other:_____

IV Flush Orders

☐ Peripheral: NS 5 mL pre-/post-use.

☐ Implanted Port: • NS 5 to 10 mL pre-/post-use • Heparin (100 unit/mL) 5 mL post-use
For maintenance, every 24 hr if accessed or weekly to monthly if not accessed.

Nursing Order: RN to complete assessment and administer Ocrevus via ambulatory pump. RN to insert peripheral IV or access central venous catheter. RN to flush IV post infusion

Ancillary supplies: Ancillary supplies, including a disposable IV pole, for the via peripheral IV, port, or indwelling central catheter via gravity or by ambulatory infusion pump.

Prescriber 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.

_____ **Substitution permissible signature**

_____ **Dispense as written signature**

_____ **Date**