



## Specialty Medication: Ocrevus Referral Form

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212 Northside Drive, Valdosta, GA 31602

Phone: 800.482.8466 | Fax: 844.259.0209

[www.aiscaregroup.com](http://www.aiscaregroup.com)

**Important: To ensure timely processing, please include the following with completed referral form:**

Insurance Information (copy of ALL insurance cards, front and back)

Demographic Information

H&P with recent Progress Notes (signed)

Relevant Diagnostic Procedures or Test Results

Relevant Lab Results

Recent Office Notes

Recent CMP or BMP Lab Results

Medication List (current)

**Note: Please fax the completed referral form to the number listed above.**

# Ocrevus (ocrelizumab) Home Infusion Referral Form

Fax completed form, insurance information, and clinical documentation to 844.259.0209. If you have any questions or need assistance, please call 800.482.8466.

## PATIENT DEMOGRAPHIC INFORMATION

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_  
 Allergies See List NKDA City, State, Zip: \_\_\_\_\_  
 Weight: \_\_\_\_\_ kg lbs Height: \_\_\_\_\_ in cm Email: \_\_\_\_\_

## PRIMARY DIAGNOSIS

G35.A (RRMS)                      G35.B1 (Active PPMS)                      G35.C2 (Non-Active SPMS)  
 G35.C0 (SPMS-NOS)              G35.C1 (Active SPMS)                      G35.D (MS-NOS)  
 G35.B0 (PPMS-NOS)              G35-B2 (Non-Active PPMS)

## PRESCRIPTION

### Ocrevus (ocrelizumab)

Initial Dose: Ocrevus 300 mg IV on Day 1 & Day 15, then 600 mg IV every 6 months after initial dose

Maintenance Dose: Ocrevus 600 mg IV every 6 months

Other: \_\_\_\_\_

Has patient received any doses of this medication in the past?    Yes    No

Refill x 12 months unless otherwise noted: \_\_\_\_\_

## REQUIRED DOCUMENTATION

- Insurance Card
- Medication List
- Negative Hep B
- H&P
- Most recent labs
- Immunoglobulin Panel
- Patient Demographics
- MRI Results

## ANCILLARY ORDERS

### ADVERSE REACTION & ANAPHYLAXIS ORDERS

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
Epinephrine (nurse required)	IM    SQ	Adult 1 mg/mL, 0.3 mL (>30 kg/70 lbs) Peds 1 mg/mL, 0.15 mL (<30 kg/33-70 lbs) May repeat in 5-15 minutes x 1 time as needed; PRN severe allergic reaction— Call 911
Diphenhydramine 50 mg/mL vial	IV    IM	Adult 25 mg (0.5 mL) >30 kg    May repeat in 5-15 minutes x 1 time as needed Peds 1.25 mg/kg <30 kg              (MAX dose is 50 mg combined— DO NOT exceed 50 mg); PRN severe allergic reaction— Call 911
Solu-Cortef 100 mg/2 mL Act-O-Vial	IV	Adult >30 kg Activate vial. Administer over 2-3 minutes
Normal saline	IV	Adult >30 kg 500 mL KVO rate PRN anaphylaxis Peds <30 kg 250 mL KVO rate PRN anaphylaxis

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## ANCILLARY ORDERS (CONT'D)

### PRE-MEDICATION ORDERS PROTOCOL - x1 DOSE PRIOR TO ADMINISTRATION

	Acetaminophen 650 mg PO
	Diphenhydramine 25 mg IV 30 minutes prior to start of infusion
	Methylprednisolone 100 mg IV 30 minutes prior to start of infusion
	Provider Prescribed: _____ _____ _____

### LINE CARE ORDERS

SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
Catheter PIV Port PICC	IV	Catheter care/flush— Only on drug admin days— SASH or PRN to maintain IV access and patency PIV—5-10 mL NS pre- and post medication, IF REMAINS 2-3 mL of 10 units/mL heparin PORT/PICC—5-10 mL NS pre- and post medication, 3-5 mL of 100 units/mL heparin

### LAB ORDERS— PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the skilled nurse: \_\_\_\_\_

## NURSING

A visit from a skilled nurse is needed to establish venous access, administer medication, and assess general status and response to therapy. Visit frequency based on prescribed orders.

If a nurse will be required for therapy administration, the home health nurse will call for additional orders per state regulations. ALL fields must be completed to expedite prescription fulfillment.

Prescriber: \_\_\_\_\_ Name of practice: \_\_\_\_\_

Office contact: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_ NPI#: \_\_\_\_\_

### PRESCRIBER SIGNATURE REQUIRED: Authorizing Above Nursing and Prescription Orders (Stamp Signature Not Allowed)

"Dispense As Written"/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute

**Prescriber's Signature**

**Date**

\_\_\_\_\_

**OR** May Substitute/Product Selection Permitted/Substitution Permissible

**Prescriber's Signature**

**Date**

\_\_\_\_\_

**CA, MA, NC, and PR:** Interchange is mandated unless Prescriber writes the words "No Substitution": \_\_\_\_\_