



Nevada Infusion

Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511

Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706

PH: 775-453-0667 | Fax: 775-470-8478

Ocrevus Order Form

Patient Name: _____ DOB: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Sex: _____ Height: _____ Weight: _____ Allergies: _____

DIAGNOSIS:

- | | |
|--|--|
| <input type="checkbox"/> Relapsing-Remitting MS ICD-10: G35A | <input type="checkbox"/> Non-Active Secondary Progressive MS ICD-10: G35C2 |
| <input type="checkbox"/> Primary-Progressive MS NOS ICD-10: G35B0 | <input type="checkbox"/> Secondary-Progressive MS NOS ICD-10: G35C0 |
| <input type="checkbox"/> Active Primary Progressive MS ICD-10: G35B1 | <input type="checkbox"/> Multiple Sclerosis, NOS ICD-10: G35D |
| <input type="checkbox"/> Active Secondary Progressive MS ICD-10: G35C1 | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Non-Active Primary Progressive MS ICD-10: G35B2 | ICD-10: _____ |

ORDER FOR OCREVUS (OCRELIZUMAB):

- ☐ 300 mg IV at 0 and 2 weeks, then 600 mg IV infused every 6 months X 1 year
☐ 600 mg IV infused every 6 months X 1 year
☒ **Patient to be observed for at least 1 hour after each infusion**

PRE-MEDICATIONS FOR OCREVUS:

- ☒ Acetaminophen 650mg PO 30 minutes prior to infusion
☒ Diphenhydramine 25-50 mg IV/PO 30-60 minutes to infusion
☒ Solumedrol 125mg IV 30 mg prior to infusion
☒ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☒ Nevada Infusion Hypersensitivity Reaction Order Set
☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line

FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml

NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____
Physician Signature: _____ Date: _____
Point of Contact: _____ Phone: _____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **



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Patient Name: _____ DOB: _____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- ☐ Signed provider orders (page 1)
- ☐ Patient demographic and insurance information
- ☐ Patient's current medication list
- ☐ Supporting documentation to include past tried and/or failed therapies
- ☐ Supporting clinical notes and H&P (to support primary diagnosis) to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
 - ☐ Expanded Disability Status Scale (EDSS) score: _____
- ☐ Include labs, imaging and/or test results to support diagnosis
 - ☐ MRI
- ☐ If applicable - Last known biological therapy: _____ and last date received: _____
_____. If the patient is switching to biologic therapies, please perform a wash out period of _____ weeks prior to starting Ocrevus.

Additional REQUIRED Information:

- ☐ Hepatitis B screening test completed within 12 months - this includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - please include results
 - ☐ Positive OR ☐ Negative
 - ☐ Serum Immunoglobulin Panel (required)
 - *If Hepatitis B results are positive - please provide documentation of treatment or medical clearance
- ☐ Other medical necessity: _____

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