



Ocrevus Order Form

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

DIAGNOSIS:

- Relapsing-Remitting MS ICD-10: G35A
- Primary-Progressive MS NOS ICD-10: G35B0
- Active Primary Progressive MS ICD-10: G35B1
- Active Secondary Progressive MS ICD-10: G35C1
- Non-Active Primary Progressive MS ICD-10: G35B2
- Non-Active Secondary Progressive MS ICD-10: G35C2
- Secondary-Progressive MS NOS ICD-10: G35C0
- Multiple Sclerosis, NOS ICD-10:G35D
- Other _____
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 mg IV/PO 30-60 minutes prior to infusion
- If necessary may give Dipenhydramine 50 mg IV/PO 30-60 minutes prior 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. ****



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: _____

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. **