Ocrevus Referral Form	Y Medical Associates Fax: 855-838-0623 Phone: 800-447-7558	YMedical ASSOCIATES

Date: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____
Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

DIAGNOSIS (ICD-10)

☐ G35 Relapsing forms of Multiple Sclerosis (Clinically isolated syndrome/relapsing-remitting disease/active secondary progressive disease)

☐ G35 Primary Progressive Multiple Sclerosis

PRE-SCREENING

☐ Hepatitis B Surface Antigen: _____
☐ Total Hepatitis B Core Antibody (Anti-HBc):_____
☐ Serum Immunoglobulins: _____ (IgG, IgA, IgM)

☐ Vaccination: _____ Height:_____ Weight:_____
Allergies: _____

(live or live-attenuated 4 weeks before, non-live 2 weeks before initiation of therapy)

Labs (During Therapy):_____
_____

Vaccinations: Live-attenuated or live vaccines is not recommended during treatment and after discontinuation until B-cell repletion. Administer all necessary immunizations according to immunization guidelines at least 4 weeks prior to initiation for live or attenuated vaccines and at least 2 weeks prior to initiation for non-live vaccines.

Pre-screening: Required Hepatitis screening before first dose to include:

☐ Hepatitis B Surface Antigen (HBsAg) and Total Hepatitis B Core Antibody (anti-HBc) * Ocrevus® is contraindicated in patients with active HBV. Patients who are negative for surface antigen HBsAg (-) and positive for HB core antibody HBcAB (+) or positive for surface antigen HBsAg (+), should consult liver disease experts before starting and during treatment.

☐ Quantitative Serum Immunoglobulin Screening (IgG, IgA, IgM)

PRESCRIPTION ORDERS

Premeds

Premedication to be given 30 minutes prior to infusion:

☐ Acetaminophen PO: ☐ 325mg ☐ 500mg ☐ 650mg
Diphenhydramine: ☐ 25mg IVP ☐ 50mg IVP ☐ 25mg PO ☐ 50mg PO
OR ☐ Alternate oral antihistamine: ☐ Cetirizine 10mg ☐ Loratadine 10mg
☐ Fexofenadine 60mgs ☐ Fexofenadine 180mgs
IV Access Flush Order: NaCl 0.9% 5-10ml IV before and after infusion

☐ Methylprednisolone ☐ 125mg IVP ☐ 40mg IVP OR ☐ ____mg PO
☐ Others/Miscellaneous:_____

Anaphylaxis Orders and Medications

Diphenhydramine Administer 25 mg slow IV/IM may repeat x1 ***Dispense****: 1 x 50 mg vial*

Epinephrine Autoinjector ☐ Administer 0.15mg (1:2000) IM (< 30 Kg)
☐ Administer 0.3mg (1:1000) IM (≥ 30 Kg)
Dispense: 1 package (2 pens)

Sodium Chloride 0.9% *Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis*
Dispense*:* QS

Medication

Ocrevus (Ocrelizumab) IV as directed to infuse per protocol via pump with 0.22 µ or 0.2 Õfilter, following each infusion with a one hour post observation period.

☐ Induction/Initial dosing: Induction/Initial dosing: 300mg Ocrevus IV in 250ml Sodium Chloride 0.9% to be infused at Week 0 over 2.5 hours or longer and 2 weeks later over 2.5 hours or longer. No Refills. ***To be infused in MD office or an Infusion suite.*

☐ Maintenance dosing: 600mg Ocrevus IV in 500ml Sodium Chloride 0.9% to be infused every 6 months. ☐ 2 hrs or longer for eligible patients who have not experienced a serious infusion reaction with any previous Ocrevus Infusion ☐ 3.5-4 hrs or longer. Refills: ☐ X1 year ***Infusions to be performed under the close supervision of a healthcare professional and to observe the patient for least one hour after completion of the infusion.*

☐ Home ☐ Infusion Suite ☐ MD Office

By signing below, I certify that above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

_____ _____ _____ _____
Dispense as Written Date Substitution Allowed Date

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