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

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.A Relapsing-remiting multiple sclerosis
☐ G35.B0 Primary progressive multiple sclerosis, unspecified
☐ Other: _____
☐ G35.C0 Secondary progressive multiple sclerosis
☐ G35.D* Multiple sclerosis, unspecified

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

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

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Patient Name: _____
Address: _____
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***Dispense**:* QS

Medication

Ocrevus Zunovo (Ocrelizumab/Hyaluronidase) SUBQ as directed to be infused per protocol by a healthcare professional. Patients monitored closely during all injections for at least one hour after the initial injection, and for at least 15 minutes after subsequent injections.

Administer 23 mL of Ocrevus Zunovo (920 mg ocrelizumab and 23,000 units hyaluronidase) SUBQ in the abdomen over 10 minutes every 6 months. ***First dose to be infused in MD office or an Infusion Suite***

Subsequent doses:
☐ 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