Palmetto Infusion Services COMPLIANCE

MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB:_____

STANDARD OCREVUS™ (ocrelizumab) PLAN OF TREATMENT

(Re) Certification Period From_____to _____

NOTE: Patient ***may be ineligible*** to receive ocrelizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery.

1. Patient Name: _____Height (inches): _____Weight (lbs):_____

2.Allergies: _____

3. Diagnosis: ☐ **G35 Relapsing Remitting Multiple Sclerosis** ☐ **G35 Primary Progressive Multiple Sclerosis**

☐ Other ICD-10 Code: _____ Diagnosis description:_____

4. Pre-medications: ☐ None *OR* *Administered 30 minutes prior to infusion* ***as selected:***

**** Premedication of Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion***

Acetaminophen:	**Diphenhydramine:** ☐ 25 mg IVP, ☐ 50mg IVP, ☐ 25 mg PO, ☐ 50mg PO or
☐ 650 mg PO	Alternate oral antihistamine to diphenhydramine:
☐ 500 mg PO	☐ Cetirizine 10 mg ☐ Loratadine 10 mg Fexofenadine ☐ 60mgs or ☐ 180mgs
☐ 325 mg PO	**Methylprednisolone:** ☐ 125 mg IVP ☐ 40 mg IVP or other _____mg IVP
☐ 1000 mg PO	Famotidine: ☐ 20mg PO, ☐ 40mg PO, ☐ 20mg IVP, ☐ 40mg IVP

Pre-medicate with other: _____

Orders:

OCREVUS™ (ocrelizumab) IV as directed to infuse per protocol via pump with 0.22-micron filter, following each infusion with a (1) one hour post observation period.

5. Frequency:

☐ Induction dose: 300 mg IV in 250ml Sodium Chloride 0.9% to be infused at 0 week and 2 weeks

☐ Maintenance dosing: Single 600 mg IV in 500ml Sodium Chloride 0.9% **every *6 months (24 weeks)***

*Maintenance dosing is scheduled 6 months from initial 0 week dosing.

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

6. Physician's Signature: _____/ _____Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____NPI: _____

7. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

Revised 6/21/18

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Guidelines for Prescribing OCREVUS™ (ocrelizumab)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

- OCREVUS™ is indicated for the treatment of adult patients with relapsing or primary progressive forms of multiple sclerosis.

___ If patient is switching biological therapies, then MD must specify wash-out period prior to starting **OCREVUS** ™ as specified of _____ weeks.
Last known biological therapy: _____ and last date received: _____.
* The concomitant use of OCREVUS ™ and other immune-modulating or immunosuppressive therapies, including immunosuppressant doses of corticosteroids, is expected to increase the risk of immunosuppression.

___ Other as requested: _____
_____

Pre-Screening: (Hepatitis screening results must be available prior to start of therapy and within last 12 months

___ **Required Hepatitis screening to include: Hepatitis B Surface Antigen (HBsAg) and Total Hepatitis B Core Antibody (anti- HBc)**
***OCREVUS™ is contraindicated in patient 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.**

** **Warnings/Precautions:** • **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 6 weeks prior to initiation of OCREVUS™ • **Infusion Reactions:** Observe patients for infusion reactions during the infusion and for at least one hour after completion of the infusion. Inform patients that infusion reactions can occur up to 24 hours after the infusion**. Reducing the Risk of Infusion Reactions and Managing Infusion Reactions Administer pre-medication (e.g., methylprednisolone or an equivalent corticosteroid, an antihistamine, and antipyretic) to reduce the frequency and severity of infusion reactions should be considered.** Subsequent courses should be administered every 24 weeks from initial 0 week dosing, but not sooner than every 20 weeks (5 months). • **Infection**: Delay administration in patients with an active infection until the infection is resolved. An increases risk of upper respiratory tract infections, lower respiratory tract infections, skin infections, and herpes infections have been reported. •**Malignancies:** An increased risk of malignancy, including breast cancer. •**Progressive Multifocal Leukoencephalopathy (PML):** At the first sign or symptom, withhold treatment and perform an appropriate diagnostic evaluation. •**Pregnancy: Women of childbearing potential should use contraception during treatment and for 6 months after the last infusion** •*See full prescribing information.*

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.