Palmetto INFUSION®

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

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Ocrevus® (ocrelizumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight: LB or KG	Gender:	Allergies: ☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ G35 - Relapsing Remitting Multiple Sclerosis

☐ G35 - Primary Progressive Multiple Sclerosis

☐ _____- Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** Hepatitis B Panel for new start patients		☐ **Continue current order until insurance approved**
6	Quantitative Serum Immunoglobulin screening		

MEDICATION ORDERS:

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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*Per FDA labeling, Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion

IV	Diphenhydramine	☐ 25mg	☐ 50mg				
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:			
	Famotidine	☐ 20mg	☐ 40 mg				
	Other:	☐					

PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg
	Famotidine	☐ 20mg	☐ 40mg		
	Diphenhydramine	☐ 25mg	☐ 50mg		
	Fexofenadine	☐ 60mg	☐ 180mg		
	Cetirizine	☐ 10mg			
	Loratadine	☐ 10mg			
	Other:	☐			

MEDICATION/FREQUENCY:

☐ Induction: Ocrevus® 300mg IV in 250ml NS to be infused over 2.5 hours or longer per step protocol at week 0 and 2 weeks

☐ Maintenance: Ocrevus® 600mg IV in 500ml NS every 6 months

Follow each infusion with a (1) one-hour post observation period.

SPECIAL/LAB ORDERS:

☐ _____

_____

MAINTENANCE INFUSION TIME:

☐ Infuse maintenance dose over 2 hours per step protocol

☐ Infuse maintenance dose over 3.5 - 4 hours per step protocol

Prescriber to monitor patient for symptoms of HBV infection and reactivation as clinically appropriate.

☑ Refills x 12 months unless noted otherwise here:

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

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	