Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order change
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:	☐					

DOSE AND FREQUENCY: PRODUCT:

- ☐ 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

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	

Palmetto
INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023