Ocrevus referral form

Infusion pharmacy

Phone:

Fax:

✂ Please detach before submitting to a pharmacy–tear here.

PATIENT INFORMATION

Acute care specialist: Name: Phone:

Patient: ☐ see attached Gender: ○ Male ○ Female

Patient name: DOB: SSN:

Address: City:

State: ZIP: Phone: Cell:

Emergency contact: Phone: Relationship:

Insurance: ☐ Front and back of insurance card to follow

Primary Insurance: Phone: Policy #: Group:

Secondary Insurance: Phone: Policy #: Group:

Primary diagnosis: ☐ Relapsing Forms of Multiple Sclerosis (MS): ☐ Isolated Syndrome ☐ Relapsing Remitting ☐ Active Secondary Progressive ☐ Primary Progressive

Medical assessment: Height: Weight: ○ lbs ○ kg

Current medications? ○ Yes ○ No If yes, list or attach:

Allergies:

PRESCRIPTION ORDERS Ocrevus, x1 year infused per PI recommended rate and via rate controlled device per therapy

☐ Initial Dose 1: 300mg in 0.9% Sodium Chloride 250mL IV Date needed:

☐ Initial Dose 2: 300mg in 0.9% Sodium Chloride 250mL IV Date needed:

☐ Subsequent Doses: 600mg in 0.9% Sodium Chloride 500mL IV once every 6 months. Date Needed:

Pre-medications, x1 year **Administer 30 minutes prior to infusion**

☐ Methylprednisolone 100 mg *(or an equivalent corticosteroid)* administered intravenously

☐ Acetaminophen PO ○ 325 mg ○ 650 mg ○ mg | ☐ DiphenhydrAMINE PO ○ 25 mg ○ 50 mg ○ mg

☐ Other:

Nursing orders, x1 year Nursing to administer prescribed medication and establish and/or maintain IV access. IV access to be flushed by nurse:
- Sodium Chloride 0.9%: 5mLs pre-infusion and 5mLs post infusion
- If port access: Sodium Chloride 0.9%, 10mLs pre-infusion and 10mLs post-infusion followed by Heparin 100 units/mL, 5mLs as final lock for patency

Pharmacy orders, x1 year

Pharmacy to dispense flushes, needles, syringes and HME/DME quantity sufficient to complete therapy as prescribed

☑ **Anaphylaxis kit order** Infusion Reaction Management x1 year

Mild
- Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated.

☑ DiphenhydrAMINE PO ○ 25mg ○ 50mg ○ mg Dispense diphenhydrAMINE 25mg capsules x 4

Moderate
- Stop Infusion, resume at 50% rate when symptoms resolve

☑ DiphenhydrAMINE IV1 ○ 25mg ○ 50mg ○ mg Dispense diphenhydrAMINE 50mg vial x 1

Severe (Anaphylaxis) *Call 911* Notify prescribing physician
- Stop infusion and remove tubing from access device to prevent further administration
- Initiate 0.9% NaCl 500mL/hr IV OR mL/hr
- **Administer EPINEPHrine 1mg/mL by weight (Wt.) as an IM injection into the lateral thigh**

Wt > 66lbs (30kg)	Wt 33 to 66 lbs (15 to 30kg)	Wt < 33lbs (15kg)
0.3mg/0.3mL	0.15mg/0.15mL	0.01mg/kg

- Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist
- Administer CPR if needed until EMS arrive

☑ Dispense 0.9% NaCl 500mL x1 ☑ Dispense EPINEPHrine 1 mg vial x 2

☐ Other medication:

PHYSICIAN INFORMATION

Name: Practice:

Address: City: State: ZIP:

Phone: Fax: NPI: Contact:

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Please fax: ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and lab ☐ Hepatitis B Screening

Substitution permissible Signature: Date: Dispense as written Signature:

This form is not a valid prescription in Arizona.

