Ocrevus® Referral Form

PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com ☐ ***Initial Order*** ☐ ***Reorder***

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ ☐ Cell Alternate Phone #: _____ ☐ Cell

Height:_____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN: _____

Allergies: _____ ☐ **NKDA**

Diagnosis Information: ☐ Multiple Sclerosis Primary Progressive G35 ☐ Multiple Sclerosis Relapsing G35

☐ Other Diagnosis/ICD10Code_____

Date Infusion to Begin: _____

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: _____

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: _____

List of Failed Therapies: _____

Labs for review prior to starting therapy: HBsAg, _____

Lab Recommended: Baseline IG level: _____

Ocrevus (Ocrelizumab)®: J2350 *Serum IG levels should be monitored during duration of therapy by physician per PI*

☐ **Loading Dose:** 300mg IV at 0 and 2 weeks, then 600 mg IV every 24 weeks for _____ months. Titrate per IVCO policy. *Nurse to Administer Methylprednisolone 100mg IV x1 30 minutes prior to infusion*.

☐ **Maintenance Dose:** 600mg IV every 24 weeks for _____ months. Titrate per IVCO policy.

Nurse to Administer Methylprednisolone 100mg IV x1 30 minutes prior to infusion.

Pre-Medications: Patient to Provide and take 30 minutes prior to infusion. ***Will receive 50ml NS post- infusion***.

☐ Benadryl 50 MG IV x1
☐ Acetaminophen 325 mg PO x1 ☐ Acetaminophen 650 mg PO x1
☐ Other Pre-medication: _____

Access: ☐**PIV** ☐ **PORT** ☐ **PICC** **Route:** ☐ **IV**

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5ml: Qty 4

PORT – NS 10ml: Qty 4, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10ml: Qty 4, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 2 per infusion
Catheter Care Supplies (A4221) – 1 per week
Infusion Pump (E0781)
Nursing services to administer medications

Administration through an in-line 0.2- or 0.22-micron filter is required

Administer the anaphylaxis protocol for adverse reactions.

Physician/PA signature: _____

NPI # _____Phone _____ Fax _____

Office Address: _____ City: _____ St ___Zip: _____

Printed MD Name: _____ Contact Name: _____

☐ Demographic information ☐ Patient Ins. Card ☐ H & P ☐ Office notes ☐ Failed therapies in documentation
☐ Up to date medication list

9/23 TSP