

Ocrevus Referral Form

Century Specialty Script Fax Referral To: 877-521-5353 Phone: 800-521-3949



Date: _____

PATIENT INFORMATION

Patient Name: Address: City, State, Zip: Home Phone: Cell Phone: Date of Birth: Gender: M F

PRESCRIBER INFORMATION

Prescriber Name: Address: City, State, Zip: Phone: Fax: DEA#: NPI#: Contact Person:

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)

Primary Insurance: ID#: Group: Secondary Insurance: ID#: Group: Prescription Card: ID#: BIN: PCN: Group:

DIAGNOSIS (ICD-10)

- G35 Relapsing forms of Multiple Sclerosis (Clinically isolated syndrome/relapsing-remitting disease/active secondary progressive disease) G35 Primary Progressive Multiple Sclerosis

PRE-SCREENING

- Hepatitis B Surface Antigen: Total Hepatitis B Core Antibody (Anti-HBc): Serum Immunoglobulins:

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 4 weeks prior to initiation for live or attenuated vaccines and at least 2 weeks prior to initiation for non-live vaccines.

Pre-screening: Required Hepatitis screening before first dose to include:

- Vaccination: Height: Weight: Allergies: Hepatitis B Surface Antigen (HBsAg) and Total Hepatitis B Core Antibody (anti-HBc) * Ocrevus is contraindicated in patients 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. Quantitative Serum Immunoglobulin Screening (IgG, IgA, IgM)

(live or live-attenuated 4 weeks before, non-live 2 weeks before initiation of therapy)

Labs (During Therapy):

PRESCRIPTION ORDERS

Premeds

- Premedication to be given 30 minutes prior to infusion: Acetaminophen PO: 325mg 500mg 650mg Diphenhydramine: 25mg IVP 50mg IVP 25mg PO 50mg PO OR Alternate oral antihistamine: Cetirizine 10mg Loratadine 10mg Fexofenadine 60mgs Fexofenadine 180mgs

IV Access Flush Order: NaCl 0.9% 5-10ml IV before and after infusion

- Methylprednisolone 125mg IVP 40mg IVP OR mg PO Others/Miscellaneous:

Anaphylaxis Orders and Medications

Diphenhydramine Administer 25 mg slow IV/IM may repeat x1 Dispense: 1 x 50 mg vial

Epinephrine Autoinjector Administer 0.15mg (1:2000) IM (< 30 Kg) Administer 0.3mg (1:1000) IM (≥ 30 Kg) Dispense: 1 package (2 pens)

Sodium Chloride 0.9% Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis Dispense: QS

Medication

Ocrevus (Ocrelizumab) IV as directed to infuse per protocol via pump with 0.22 µm filter, following each infusion with a one hour post observation period.

Induction/Initial dosing: Induction/Initial dosing: 300mg Ocrevus IV in 250ml Sodium Chloride 0.9% to be infused at Week 0 over 2.5 hours or longer and 2 weeks later over 2.5 hours or longer. No Refills. **To be infused in MD office or an Infusion suite.

Maintenance dosing: 600mg Ocrevus IV in 500ml Sodium Chloride 0.9% to be infused every 6 months. hrs or longer for eligible patients who have not experienced a serious infusion reaction with any previous Ocrevus Infusion 3.5-4 hrs or longer. Refills: X1 year **Infusions to be performed under the close supervision of a healthcare professional and to observe the patient for least one hour after completion of the infusion.

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By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written

Date

Substitution Allowed

Date