

**OCREVUS ORDER FORM**

Date: _____	ICD-10 Code: _____
Patient Name: _____	Allergies: _____
Date of Birth: _____	Weight: _____ lbs OR _____ kg
<b>Therapy Status</b>	<b>Provider Information</b>
<input type="checkbox"/> New Start  <input type="checkbox"/> Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

**MEDICATION ORDER**

<input type="checkbox"/> Ocrevus	<input type="checkbox"/> Initiation: Infuse Ocrevus 300mg IV per protocol on Day 1 and Day 15.  <input type="checkbox"/> Maintenance: Infuse Ocrevus 600mg IV every six months. If first maintenance dose, schedule six months from Day 1 of initiation phase.  <input checked="" type="checkbox"/> Pre-medications will be given as indicated below unless otherwise specified. Antihistamine dosage and route to be determined by on site provider.	Refills x one year from date of signature unless indicated below.  <input type="checkbox"/> _____ Refills	<p><i>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</i></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Hepatitis B Surface Antigen.</li> <li><input checked="" type="checkbox"/> Hepatitis B Core Antibody.</li> <li><input checked="" type="checkbox"/> Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment)</li> </ul>
----------------------------------	---	---	---

**PRE-MEDICATIONS**

**\*\*To be given 30-60 minutes prior to infusion\*\***

<p><b>Oral</b></p> <input checked="" type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg <input checked="" type="checkbox"/> 650mg <input type="checkbox"/> Loratadine: _____ 10mg <input type="checkbox"/> Cetirizine: _____ 10mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p><b>IV</b></p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input checked="" type="checkbox"/> Methylprednisolone: <input checked="" type="checkbox"/> 125mg <input type="checkbox"/> Hydrocortisone: _____ 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
--	---

**LAB ORDERS** (please indicate any labs to be drawn and frequency)

**OTHER REQUIRED DOCUMENTATION**

**Surveillance lab ordering and monitoring is the responsibility of the prescriber**	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> <li>• History &amp; Physical, Last Office Visit Note</li> <li>• Patient Demographics and Insurance Information</li> <li>• Medication List</li> <li>• Recent Lab Work</li> </ul>
--	--

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

Dispense as Written: _____	Substitution Allowed: _____
Prescriber Name _____ Date _____	Prescriber Name _____ Date _____