CarePartners Specialty Infusion

Ocrevus Enrollment Form

Fax Referral To: 866-832-7180
Phone: 866-852-0202

To better serve your patient and facilitate insurance authorization, please attach the following:

- **Patient demographics, H&P, and labs**
- **The front and back of insurance & prescription drug card**
- **Labs – Antibody testing, BUN/SCr, IgA, IgG (including subclasses) levels**

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

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

CLINICAL INFORMATION

DIAGNOSIS:

☐ G35 Primary Progressive Multiple Sclerosis

☐ G35 Relapsing Remitting Multiple Sclerosis

☐ Other _____

PATIENT EVALUATION:

Has patient previously received Ocrevus? ☐ Yes ☐ No

If so, date of last infusion with Ocervus: _____ Next dose due: _____

Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

Allergies: _____

Required Hepatitis B virus screening results:

☐ Negative ☐ Positive (Contraindicated) Date Read: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY DISPENSE	REFILLS
☐ Ocrevus	☐ INITIAL: 300mg IV on day 1 and day 15	Dispense day 1 and day 15	0
	☐ Maintenance: 600mg IV every 6 months starting 6 months after day 1 dose	1 cycle	ONE

FLUSH PROTOCOL: to be provided for IV drug administration days only.
To be infused peripherally, unless otherwise indicated. ☐ PORT ☐ PICC

- 0.9% NaCl: 1-5ml intravenous (peripheral line) or 10ml intravenous (central line) before/after infusion, or as needed for line patency/SASH.
- Heparin 10 units/ml: 5ml intravenous (peripheral line) as needed for final flush.
- Heparin 100 units/ml: 5ml intravenous (central line) as needed for final flush.

HYDRATION:
Please select only if needed

☐ 0.9% NaCl _____ ml infused over _____ minutes
☐ D5W _____ ml infused over _____ minutes

*To be infused pre-IVIG infusion, unless otherwise specified below.

☐ Post-IVIG Infusion
☐ To be completed concurrently during the IVIG infusion

PREMEDICATIONS: to be given 30 minutes prior to infusion *(PLEASE STRIKE THROUGH IF NOT REQUIRED)*

Diphenhydramine 25mg-50mg by mouth Acetaminophen 325mg-650mg by mouth Methylprednisolone 100mg slow IV push

MEDICATIONS to be used as needed/requested by patient/nurse *(PLEASE STRIKE THROUGH IF NOT REQUIRED)*

- Diphenhydramine: May repeat premedication dose every 4-6 hours as needed. Adult max: 100mg/day.
- Acetaminophen: May repeat premedication dose every 4-6 hours as needed. Adult max: 3000mg/day.
- Lidocaine 2.5%/Prilocaine 2.5% topical (may dispense Lidocaine 4%) to injection sites at least 1 hour prior to needle insertion.

ANAPHYLAXIS PROTOCOL: Pharmacy to provide the following as needed for anaphylactic reaction:

- Diphenhydramine 25mg- 50mg PO as needed for mild-moderate reaction. qty: 2
- Diphenhydramine 25mg- 50mg via slow IV push as needed for moderate-severe reaction. qty: one 50mg/ml vial
- Sodium Chloride 0.9% 500ml bag IV PRN for anaphylactic reaction. qty: 500ml
- Epinephrine 0.3mg (patient's weighing ≥ 30kg/66lbs)
- Epinephrine 0.15mg (patient's weighing between 15-30kg/33-66lbs)

Administer intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1.

DELIVERY METHOD: To be infused via gravity infusion, unless otherwise indicated ☐ MD prefers Infusion Pump
RATE: Initial and maintenance infusions to be titrated per manufacturer guidelines.

NURSING: Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No

ADDITIONAL: _____

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____

☐ Dispense as Written
☐ Product Substitution Permitted