

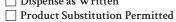
To better serve your patient and facilitate insurance authorization, please attach the following: • Patient demographics, H&P, and labs • The front and back of insurance & prescription drug card • Labs – Antibody testing, BUN/SCr, IgA, IgG (including subclasses) levels						
PATIENT INFORMATION PRESCRIBER INFORMATION						
Patient Name:			Prescriber Name:			
Address: City, State, Zip:						
Home Phone:	Cell Phone:	City, St Phone:		F <u>ax:</u>		
Date of Birth:	Gender:	DEA #:		NPL#:		
Emergency Contact:	Phone:	Contac	t Person:			
CLINICAL INFORMATION						
DIAGNOSIS: PATIENT EV			EVALUATION:			
G35 Primary Progressive Multiple Sclerosis			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			
Other 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	d 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		
 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: 0.9% NaCl ml infused over minutes D5W ml infused over minutes Post-IVIG Infusio To be completed over *To be infused pre-IV otherwise specified be completed over			elow.			
PREMEDICATIONS: to be given 30 minutes prior to infusion (PLEASE STRIKE THROUGH IF NOT REQUIRED)						
Diphenhydramine 25mg-50mg by mouthAcetaminophen 325mg-650mg by mouthMethylprednisolone 100mg slow IV push						
 MEDICATIONS to be used as needed/requested by patient/nurse (PLEASE STRIKETHROUGH 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 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. 🔲 Dispense as Written

_ Date: ____

Prescriber Signature: _

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