OCRELIZUMAB (OCREVUS®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

Patient Name:		**Date of Birth:**	
Address:			
Phone:	**Height:** ☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:		**ICD-10 Code:**	
Is this the first dose?	☐ Yes – date of first dose: ☐ No – date of next dose due:	**Hepatitis B Status:**	Titer Date: ☐ Positive ☐ Negative

Ocrelizumab (Ocrevus®) Prescription

Ocrelizumab (Ocrevus®) 300 mg refill as directed x 1 year

Initial Dose: ☐ Infuse 300 mg IV over at least 2.5 hours on Week 0 and 2.

☐ Other: ______________________________

Maintenance Dose: ☐ Infuse 600 mg IV over at least 3.5 hours every 6 months.

☐ Other: ______________________________

If planned maintenance dose of ocrelizumab is missed, administer dose ASAP and reset dosing schedule to six months after the missed dose. Maintenance doses must be separated by at least 5 months.

Ancillary Orders

Anaphylaxis Kit

➔ Required per Option Care Health Policy – please complete Anaphylaxis Physician Order (FR-PC-036) provided.

Medication Orders

☐ Methylprednisolone 100 mg IV over 15 to 60 min; 30 min prior to infusion.

☐ Acetaminophen __________ mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may use own supply or patient may decline.

☐ Diphenhydramine __________ mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may use own supply or patient may decline.

☐ Other: ______________________________

IV Flush Orders

☐ Peripheral: NS 2 to 3 mL pre-/post-use.

☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Other: ______________________________

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: ______________________________ **Date:** __________

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

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