

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ Phone: _____ Allergies: _____
 City, State, Zip: _____ Email: _____

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

Is this the first dose? Yes No, date of last infusion: _____ Line type: PIV PICC Port Other

DIAGNOSIS AND ICD-10 CODE

- | | |
|---|---|
| <input type="checkbox"/> Relapsing-remitting multiple sclerosis (G35.A) | <input type="checkbox"/> Primary progressive multiple sclerosis, unspecified (G35.B0) |
| <input type="checkbox"/> Primary progressive multiple sclerosis, active (G35.B1) | <input type="checkbox"/> Primary progressive multiple sclerosis, non-active (G35.B2) |
| <input type="checkbox"/> Secondary progressive multiple sclerosis, unspecified (G35.C0) | <input type="checkbox"/> Secondary progressive multiple sclerosis, active (G35.C1) |
| <input type="checkbox"/> Secondary progressive multiple sclerosis, non-active (G35.C2) | <input type="checkbox"/> Multiple sclerosis, unspecified (G35.D) |

REQUIRED DOCUMENTATION

- | | |
|---|---|
| <input type="checkbox"/> This signed order form by the provider | <input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis |
| <input type="checkbox"/> Patient demographics AND insurance information | <input type="checkbox"/> Labs and Tests supporting primary diagnosis |
| <input type="checkbox"/> Pregnancy Test (if applicable) | <input type="checkbox"/> Hepatitis B Test Results: HBsAg & Total HepB Core Antibody |

Current MS treatment and end of current therapy date: _____

MEDICATION ORDERS

Initial dosing	<input type="checkbox"/> Ocrevus 300 mg IV given at week 0 and 2
Maintenance Dosing	<input type="checkbox"/> Ocrevus 600 mg IV every 6 months

Refills: X 6 months X 1 Year Other: _____

- RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
 RN to flush and lock VAD/CVAD per company protocol:

*** Infusions will be titrated to maximum recommended rate as suggested in prescribing information.*

PREMEDICATIONS

- Acetaminophen 650mg PO prior to infusion
 Diphenhydramine 25mg PO prior to infusion
 Methylprednisolone 100 mg Slow IV Push prior to infusion
 Other: _____

EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
 Acetaminophen 325mg-650mg PO
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.3mg IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive
 Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
 Diphenhydramine 25mg slow IV push over 2-5 mins
 Acetaminophen 325mg PO
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____
 Office Phone: _____ Office Fax: _____
 Prescriber Signature: _____ Date: _____