Ocrevus Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card, 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: *OCREVUS® (ocrelizumab)*

☐ **Loading Dose: Ocrevus 600 mg IV divided into 2 infusions** _____# Refills (Recommend 1 Refills)
Administer 300 mg IV over 2.5 hours on 0 week and 2 weeks.

☐ **Maintenance Dose: Ocrevus 600 mg IV every 24 weeks**
Administer 600 mg IV over 2 hours or _____ hours – 24 weeks after the most recent infusion

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO, Diphenhydramine 50 mg IV, and methylprednisolone 125 mg IV
Administered 30 min prior to infusion *Adjust to patient's needs

☐ Famotidine 20 mg administered IV 30 minutes prior to the start of the infusion

☐ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)
By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date