Phone : 844-800-5377 Fax : 214-782-9155

# OCREVUS (IV) RX ENROLLMENT FORM

## PATIENT INFORMATION

| Patient Name: | Date of Birth: | Gender: |
|---|---|---|

| Home Phone: | Cell Phone: | Email: |
|---|---|---|

| Address: | City: | State: | Zip: |
|---|---|---|---|

| Emergency Contact: | Emergency Phone: |
|---|---|

## CLINICAL INFORMATION

**Diagnosis:**
- ☐ G35 Primary Progressive Multiple Sclerosis
- ☐ G35 Relapsing Remitting Multiple Sclerosis
- ☐ Other: ____________________

**Patient Weight:** __________ ☐ kg ☐ lbs
Patient Height: __________ ☐ cm ☐ in
Allergies: ____________________

Required Hepatitis B screening results:
☐ Negative ☐ Positive (Contraindicated) Date Read: __________

Has patient previously received Ocrevus?
☐ No ☐ Yes, date of last infusion with Ocrevus: __________
Next dose due: __________

## PRESCRIBER INFORMATION

Prescriber Name: ____________________
DEA #: __________ NPI #: __________
Address: ____________________
City: __________ State: ______ Zip: __________
Phone: __________ Fax: __________
Contact Person: ____________________

Pharmacy to coordinate home health nursing visit and/or nursing training as necessary.

## PRESCRIPTION INFORMATION

| Medication | Dose and Directions | Quantity Dispense | Refills |
|---|---|---|---|
| ☐ **Ocrevus** | ☐ Initial Dose: Infuse 300mg IV on Day 1 and Day 15. | Day 1 and Day 15 | 0 |
| | ☐ Maintenance Dose: Infuse 600mg IV every 6 months starting 6 months after Day 1 dose. | 1 cycle | ONE |
| | Monitor patient closely during and for at least 1 hour after infusion<br>Rate Protocol: Titrate initial and maintenance infusions per manufacturer's product labeling. | | |

## REQUIRED FOR HOME INFUSION

**RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.**

| | |
|---|---|
| **IV Access** | **To be administered PERIPHERALLY, unless otherwise indicated.** ☐ PORT ☐ PICC |
| **Flush Protocol** for drug admin days only | • 0.9% NaCl: 1-10mL IV before/after infusion, or PRN for line patency/SASH.<br>• Heparin 100 units/mL: 5mL IV (central) PRN for final flush. |

| **Pre and Post Medications** Please strikethrough if not required | | | |
|---|---|---|---|
| **Diphenhydramine** | 25mg-50mg | Adult max: 100mg/day | **To be given by mouth 30 minutes prior to infusion. May repeat every 4-6 hours as needed.** |
| **Acetaminophen** | 325mg-650mg | Adult max: 3000mg/day | |
| **Methylprednisolone Sodium Succinate** | 100mg | | **To be given via slow IV push 30 minutes prior to infusion.** |

| | |
|---|---|
| **Anaphylaxis Protocol** | **To be given intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1.**<br>• Epinephrine 0.3mg ( ≥30kg/66lbs) • Epinephrine 0.15mg (15kg to 30kg /33lbs to 66lbs) |
| **Diphenhydramine** Please select only if needed for IVIG | **To be given via slow IV push PRN for moderate – severe reaction.**<br>☐ 25-50mg |
| **Additional Orders** | |

## PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

*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.*

☐ May Substitute/Product Selection Permitted/Substitution Permissible
**Prescriber Signature** ____________ **Date** ________

☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute
**Prescriber Signature** ____________ **Date** ________

**CA, MA, NC & PR**: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ____________ **NY & Iowa** providers, please submit electronic prescription.

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