

INFUSION & MEDICAL CENTER

1. _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please complete/select appropriate diagnosis):

Primary Diagnosis: _____ Relapsing Multiple Sclerosis ICD-10 Code: G35_____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
- Hepatitis B Screening Results

Patient
Weight: _____ lbs.
Height: _____ in.

OCREVUS® (ocrelizumab)

J Code: J2350

4. Drug Order:

Loading Dose: Ocrevus 600 mg IV divided into 2 infusions

Administer 300 mg IV over 2.5 hours on 0 week and 2 weeks.

Maintenance Dose: Ocrevus 600 mg IV every 24 weeks _____ # Refills (Recommend 1 Refills)

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 this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. **Physician Signature:** _____ / _____ Date: _____

Dispense as written

Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337
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