INTRAMED Plus
infusion services

OCREVUS®

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 diagnsosis):

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	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE
ALTERNATE FAX 803.999.1887	CENTRAL INTAKE PHONE 803.999.1960