InfuCare Rx

Ocrevus Referral Form

of Pages Faxed:_____
Fax Referral To: 877-828-3941
Phone: 877-828-3940

Date Required:_____ Ship To: ☐ Home ☐ Office ☐ Other:_____

PATIENT INFORMATION

Patient Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____
Cell Phone:_____
Alternate Phone:_____
Date of Birth:_____

PRESCRIBER INFORMATION

Prescriber Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____
DEA #:_____ NPI #:_____
Contact Person:_____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance:_____ ID:_____ Group:_____
Secondary Insurance:_____ ID:_____ Group:_____
Prescription Card:_____ ID:_____ BIN:_____ PCN:_____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS/CLINICAL INFORMATION

Primary Diagnosis:

☐ G35 Multiple Sclerosis
☐ Other ICD-10:_____
Number of Relapses the past year:_____
Date of Diagnosis:_____

Therapy: ☐ New ☐ Reauthorization ☐ Restart
Date of last infusion with Ocrevus®:_____ Next dose due:_____
Patient Weight:_____ ☐ kg ☐ lbs Height:_____ ☐ cm ☐ in
Allergies:_____
Concomitant Medications:_____
Comorbidities:_____
Hepatitis B virus screening (HBsAg and anti-HBV test) required:
☐ Negative
☐ Positive (Contraindicated)

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity/Refills:
☐ Ocrevus® (ocrelizumab) Initial Dose (two infusions)	300 mg/10 mL SDV Vials are diluted in NS to a final concentration of 1.2 mg/mL	**Infusion 1**: 300 mg in 250 mL of 0.9% NS. **Infusion 2** (2 weeks later): 300 mg in 250 mL of 0.9% NS. Start infusion at 30 mL per hour. Increase by 30 mL per hour every 30 minutes. Maximum: 180 mL per hour. Duration 2.5 hours or longer.	Dispense: ☐ 1 month supply No refills
☐ Ocrevus® (ocrelizumab) Subsequent doses (one infusion)	300 mg/10 mL SDV Vials are diluted in NS to a final concentration of 1.2 mg/mL	Every 6 months infuse 600 mg in 500 mL of 0.9% NS. Start infusion at 40 mL per hour. Increase by 40 mL per hour every 30 minutes. Maximum: 200 mL per hour. Duration 3.5 hours or longer.	Dispense: ☐ 1 month supply Refills: ☐ 1 ☐ 0

PREMEDICATION ORDERS/OTHER MEDICATIONS

Pre-Medications & Other Medications

☐ Acetaminophen 650 mg PO 30 min prior to infusion
☐ Diphenhydramine 50 mg PO 30 min prior to infusion
☐ Methylprednisolone 100 mg IV 30 min prior to infusion
☐ Other:_____
☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol

☐ Labs to be drawn:_____ Frequency:_____

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

X_____ X_____

PRODUCT SUBSTITUTION PERMITTED (Date) **DISPENSE AS WRITTEN** (Date)

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