InfuCare Rx®

Ocrevus®
Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940
referrals@infucarerx.com
www.infucarerx.health

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

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.A Relapsing-remitting multiple sclerosis
☐ G35.B0 Primary progressive multiple sclerosis, unspecified
☐ G35.B1 Active primary progressive multiple sclerosis
☐ G35.B2 Non-active primary progressive multiple sclerosis
☐ G35.C0 Secondary progressive multiple sclerosis, unspecified
☐ G35.C1 Active secondary progressive multiple sclerosis
☐ G35.C2 Non-active secondary progressive multiple sclerosis
☐ G35.D Multiple sclerosis, unspecified
☐ Other ICD-10: _____

Number of Relapses the past year: _____
Date of Diagnosis: _____
☐ Labs to be drawn: _____
Frequency: _____

Therapy: ☐ New ☐ Reauthorization ☐ Restart
Date of last infusion with Ocrevus®: _____ Next dose due: _____
Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Concomitant Medications: _____
Comorbidities: _____

Required laboratory documents prior to first dose:
☐ Hepatitis B virus screening (HBsAg and anti-HBV test) required:
  ☐ Negative
  ☐ Positive (Contraindicated)
☐ LFTs (ALT, AST, alkaline phosphatase, and bilirubin levels)
☐ Quantitative serum immunoglobulin IgG, IgA, IgM

PRESCRIPTION INFORMATION

Medication Ocrevus® (ocrelizumab):	**Dose/Strength:**	**Directions:**	**Quantity/Refills:**
☐ Initial Dose (two infusions)	300 mg in 250mL	**Day 1**: 300mg in 250mL of 0.9% NS. **Day 15:** 300mg in 250mL of 0.9% NS. Start infusion at 30mL/hr. Increase by 30mL/hr every 30 minutes. Maximum: 180mL/hr. Duration 2.5 hours or longer.	Dispense: ☐ 1 month supply No refills
☐ **Option 1:** 3.5 hour duration Subsequent doses (one infusion)	600mg in 500mL	Beginning 6 months after Day 1 infusion: Every 6 months infuse 600mg in 500mL of 0.9% NS. Start infusion at **40mL/hr**. Increase by 40mL/hr every 30 minutes. **Maximum: 200mL/hr. Duration 3.5 hours or longer.**	Dispense: ☐ 1 month supply Refills: ☐ 1 ☐ 0
☐ **Option 2:** (if no previous serious infusion reactions to ocrelizumab) 2 hour duration Subsequent doses (one infusion)	600mg in 500mL	Beginning 6 months after Day 1 infusion: Every 6 months infuse 600mg in 500mL of 0.9% NS. Start infusion at **100 mL/hour** for first 15 minutes; increase to 200 mL/hour for the next 15 minutes; increase to 250 mL/hour for the next 30 minutes; increase to 300 mL/hour for the remaining 60 minutes. **Maximum: 300 mL/hr. Duration 2 hours or longer.**	Dispense: ☐ 1 month supply Refills: ☐ 1 ☐ 0

PREMEDICATION ORDERS/OTHER MEDICATIONS

Recommended Premedications & Other Medications

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

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

X _____

DISPENSE AS WRITTEN (Date)

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