promptcare

Intake Specialist 1-866-776-6782
Fax: 800-815-6808
newreferral@promptcare.com

Ocrevus (ocrelizumab) I Order Form

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

☒ Copy of insurance card ☒ Patient demographics ☒ History & physical

☒ Labs; including quantitative serum immunoglobulins and HBV (may include HCV, HIV, TB if indicated based on patient risk factors)

2. Patient Information

☐Male ☐Female Height: _____ in/cm Weight: _____ lbs/kg ☐NKDA Allergies: _____

Is this the first dose? ☐Yes ☐No, date of last infusion: _____ Next due: _____ Line type: ☐PIV ☐PICC ☐Port ☐Other

3. Diagnosis and Clinical Information

ICD-10 (required): _____ Primary diagnosis: ☐ Multiple sclerosis _____ ☐ Other: _____

4. Prescription Information

Medication	**Ocrevus 300 mg (30 mg/mL) single-dose vial(s)**
Dose / Frequency	☐ Initial and maintenance dosing: Ocrevus 300 mg IV on days 1 and 15, then 600 mg every 6 months ☐ Maintenance dosing only (initial dosing already complete): Ocrevus 600 mg IV every 6 months ☐ Other: _____
Directions	☒ Dilute per manufacturer guidelines in compatible IV fluid. Administer the diluted solution using a 0.2 or 0.22 micron in-line filter, infused per protocol based on dose and tolerability. ☐ Other: _____
Quantity / Refills	☒ Disp+ense QS on all selected medications / Refill x 12 months ☐ Other: _____ Dispense all medical supplies necessary for infusion

5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per PromptCare Policy and Procedure

Premedications: Give standard premedications 30 min prior to infusions

☒ Diphenhydramine 25-50 mg PO, indicate if IV required: ☐ give slow IV push (over 2-3 min as tolerated)

☒ Methylprednisolone 100 mg slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

☒ Acetaminophen 325-650 mg PO

☐Other: _____

☒ RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.

☒ RN to monitor patient for at least 1 hour post infusion and educate on possible side effects, allergic reactions, and when to contact physician

6. Adverse Reaction Orders

Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

License No.: _____ DEA NO.: _____ NPI: _____

_____ _____ _____ _____

Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date