

Ocrelizumab (Ocrevus)



Provider Order Form rev. 10/12/2022

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date:	Patient Name:	DOB:
ICD-10 code (required):		ICD-10 description:
<input type="checkbox"/> NKDA Allergies:	Weight (lbs/kg):	Height:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Last Treatment Date:	Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

- ☒ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 05.01.2023)
☐ Hepatitis B status & date (list results here & attach clinicals):

Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Ocrevus induction.

- ☐ I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals):
☐ I instruct IVX Health to draw quantitative serum immunoglobulin prior to first induction infusion (if required by payor).

PRE-MEDICATION ORDERS

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ famotidine (Pepcid) 20mg PO
☐ methylprednisolone (Solu-Medrol) 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

THERAPY ADMINISTRATION

- ☒ **Ocrelizumab** (Ocrevus) intravenous infusion
☐ Induction:
▪ Dose: 300mg in 250ml 0.9% sodium chloride
▪ Frequency: on Day 1 and Day 15
▪ Rate: Start at 30ml/hr, increasing by 30ml/hr every 30 minutes to a maximum rate of 180ml/hr
▪ Duration should be at least 2.5 hours
▪ After induction, continue with maintenance dosing below
☐ Maintenance:
▪ Dose: 600mg in 500ml 0.9% sodium chloride
▪ Frequency: every 6 months from infusion 1 of initial dose
☒ Rate: Choose one:
☐ Infuse over 3.5 hours (Start at 40ml/hr, increase by 40ml/hr every 30 minutes, max 200ml/hr)
☐ Infuse over 2 hours (Start at 100ml/hr x15 min, 200ml/hr x15 min, 250ml/hr x30 min, 300ml/hr until completion)

NOTE: If rate not indicated and no prior serious infusion reaction with previous infusion, will infuse over 2 hours

- ☒ Flush with 0.9% sodium chloride at the completion of infusion
☒ Patient required to stay for 60-min observation post infusion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

*Hepatitis B virus and quantitative serum immunoglobulin screening are required before the first dose. *Pre-medicate with methylprednisolone (or an equivalent corticosteroid) and an antihistamine (e.g., diphenhydramine) prior to each infusion. *Monitor patients closely during and for at least one hour after infusion.

Provider Name (Print)

Provider Signature

Date

FAX NUMBERS

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> AUSTIN: 512-772-2824 | <input type="checkbox"/> CONNECTICUT: 860-955-1532 | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> NORTH CENTRAL FL: 352-756-4191 | <input type="checkbox"/> RALEIGH: 919-287-2551 |
| <input type="checkbox"/> BAY AREA: 844-889-0275 | <input type="checkbox"/> DAYTONA: 386-259-6096 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> NORTH JERSEY: 551-227-2823 | <input type="checkbox"/> SAN ANTONIO: 726-238-9950 |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143 | <input type="checkbox"/> DELAWARE: 302-596-8553 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> NORTHWEST AR: 888-615-1445 | <input type="checkbox"/> SARASOTA: 941-870-6550 |
| <input type="checkbox"/> CHICAGO: 312-253-7244 | <input type="checkbox"/> EAST TN: 615-425-7427 | <input type="checkbox"/> LAKELAND: 863-316-3910 | <input type="checkbox"/> ORLANDO: 844-946-0867 | <input type="checkbox"/> SOUTH JERSEY: 856-519-5309 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> FT. LAUDERDALE: 754-946-2052 | <input type="checkbox"/> LITTLE ROCK: 501-451-5644 | <input type="checkbox"/> PALM BEACH: 561-768-9044 | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 |
| <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> MIAMI: 786-744-5687 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> TAMPA: 844-946-0849 |
| | <input type="checkbox"/> HOUSTON: 832-631-9595 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 | <input type="checkbox"/> PIEDMONT TRIAD: 336-790-2200 | <input type="checkbox"/> WEST TN: 888-615-1445 |