US infusions
11500 State Hwy 121 Ste 910, Frisco, TX 75035
P: 469-200-2605 F: 469-200-2606 usinfusions.org

OCRELIZUMAB ORDER SET

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

DIAGNOSIS AND ICD-10 CODE:

Diagnosis: Multiple Sclerosis **ICD-10 Code:** G35

Type: ☐ Relapsing-Remitting ☐ Primary-Progressive ☐ Secondary-Progressive ☐ Clinically Isolated

Weight: _____ lbs Allergies: _____

PRESCRIPTION:

Ocrevus (ocrelizumab) IV:

☐ **Initial start:** 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x 1 year

☐ 600mg IV every 6 months x 1 year

Protocol IV Pre-medication Orders: Solu-Medrol 100mg IV and diphenhydramine 25mg PO 30 minutes before infusion

Substitute diphenhydramine with: ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO
☐ Cetirizine 10mg IV

Ocrevus Zunovo (ocrelizumab/hyaluronidase):

☐ 920mg/23,000units subcutaneously every 6 months x 1 year

Protocol SubQ Pre-medication Orders: dexamethasone 20mg PO & cetirizine 10mg PO 30 minutes before injection

Lab Orders: _____ **Lab Frequency:** _____

Other orders: _____

US Infusions will follow office protocol for anaphylaxis.

PROVIDER INFORMATION:

By signing this form, you authorize US Infusions and its staff to handle prior authorizations, coordinate with insurance providers, and determine the patient's preferred site of care.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

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REQUIRED DOCUMENTATION FOR OCREVUS THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

PLEASE INCLUDE DOCUMENTATION BELOW FOR PRIOR AUTHORIZATION:

- ☐ signed and completed order (MD/prescriber to complete page 1)
- ☐ Patient demographic information and insurance information
- ☐ Patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to therapy
  - ☐ Expanded Disability Status Scale (EDSS) score: _____
- ☐ Include labs and/or test results to support diagnosis
  - ☐ MRI

- ☐ *If applicable* - Last known biological therapy: _____ and last date received: _____ If patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting ocrelizumab.

- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING:

- ☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - attach results**
  - ☐ **Positive** ☐ **Negative**

*If Hepatitis B results are positive - please provide documentation of treatment or medical clearance

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606