



## OCREVUS (OCRELIZUMAB) INFUSION ORDERS

**P:** 331-236-0610 | **F:** 331-314-8989

### PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

|                                                                                                     |        |                                                                       |                                                                   |
|-----------------------------------------------------------------------------------------------------|--------|-----------------------------------------------------------------------|-------------------------------------------------------------------|
| Name:                                                                                               | DOB:   | Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male |                                                                   |
| Address:                                                                                            | City:  | State:                                                                | ZIP:                                                              |
| Phone:                                                                                              | Email: | Height: <input type="checkbox"/> inches <input type="checkbox"/> cm   | Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg |
| Allergies:                                                                                          |        |                                                                       |                                                                   |
| <b>Diagnosis Code ICD-10 (required):</b>                                                            |        | <b>Diagnosis Description:</b>                                         |                                                                   |
| Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy |        | Next Treatment Date:                                                  |                                                                   |

### PHYSICIAN INFORMATION

|                  |        |             |
|------------------|--------|-------------|
| Prescriber Name: | Phone: | Fax:        |
| Office Contact:  | Email: |             |
| Address:         | City:  | State: ZIP: |
| NPI #:           | DEA#:  | Tax ID:     |

### INSURANCE INFORMATION (or attach copy of cards)

|                      |           |          |
|----------------------|-----------|----------|
| Primary Insurance:   | Policy #: | Group #: |
| Secondary Insurance: | Policy #: | Group #: |

### PRESCRIPTION INFORMATION (or attach a copy of the prescription)

| Drug                                                    | Dosing                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Refills                                                             |
|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| <b>Ocrevus</b><br>(ocrelizumab)                         | <input type="checkbox"/> 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months<br><input type="checkbox"/> 600mg IV every 6 months<br><u>Pre-medication Orders:</u> Solu-Medrol 100mg IV and diphenhydramine 25mg PO 30 minutes before infusion (if no contraindications)<br><br>Substitute diphenhydramine with:<br><input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Cetirizine 10mg IV | <input type="checkbox"/> x 1 year<br><input type="checkbox"/> _____ |
| <b>OcrevusZunovo</b><br>(ocrelizumab/<br>hyaluronidase) | <input type="checkbox"/> 920mg/23,000units subcutaneously every 6 months<br><u>Pre-medication Orders:</u> dexamethasone 20mg PO and cetirizine 10mg PO 30 minutes before injection (if no contraindications)                                                                                                                                                                                                                                               | <input type="checkbox"/> x 1 year<br><input type="checkbox"/> _____ |

Other orders: \_\_\_\_\_

Lab Orders: \_\_\_\_\_ Lab frequency: \_\_\_\_\_

Required labs to be drawn by: ☐ LIVbetter ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

### PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing LIVbetter Infusions, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

**Prescriber Signature: X**

**Date:**



## COMPREHENSIVE SUPPORT FOR OCREVUS (OCRELIZUMAB) THERAPY

### PATIENT INFORMATION

Name:

DOB:

### REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include 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 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
- ☐ **Liver function tests including bilirubin**