Infusion Specialist
c:
e:

Ocrelizumab (Ocrevus)
Patient Referral Form

PATIENT INFORMATION

Date: Patient Name: Last 4 SSN DOB:

Address: City: ST: Zip:

Primary Phone: Work Phone:

Gender: ☐M ☐F Weight lbs/kg: ICD-10 code: ICD-10 Description:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy (If yes, did patient have reaction with 1st dose? ☐ Y ☐ N)

☐ Next Due Date (if applicable):_____

Primary Insurance: **Secondary Insurance:**

Member#: **Group#:** **Member#:** **Group#:**

ATTACH DOCUMENTS TO FAX

☑ Copy of insurance card(s) ☑ Labs ☑ Immunization results, include HBV and TB
☑ Patient demographics ☑ H&P (clinical) Other: _____

NURSING

☑ Provide nursing care per Axiva Standard Nursing Procedures, including reaction management & post-infusion observation
☑ Quantitative serum immunoglobulin (list results here & attach clinicals):

☑ Hepatitis B status & date (list results here & attach clinicals):

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50 mg ☐ PO / ☐ IV
☐ famotidine (Pepcid) 20mg PO
☐ methylprednisolone (Solu-Medrol) 125mg IV

☐ Other: _____
Dose: _____ Route: _____
Frequency:

LABORATORY ORDERS

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

SPECIAL INSTRUCTIONS:

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 remainder of infusion)

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 / ☐ Other:
(if not indicated order will expire one year from date signed)

PROVIDER INFORMATION

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Axiva Health Solutions, Inc., has my permission to contact the patient's health plan to obtain authorizations necessary to enable it to receive payment for services.

Physician Name: NPI: DEA: License:

Address: City: ST: Zip:

Phone: Fax: Office Contact:

_____ _____ ♦ _____ _____
Physician Signature Required – Substitution Permitted Date Physician Signature Required – Dispense as Written Date

FAX completed form to Axiva 844.440.0101 **Patient Navigator 844.44-AXIVA (844.442.9482)**