



Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

OCREVUS MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ Patient's weight in pounds _____

■ Diagnosis

G35 Multiple Sclerosis Other: _____

■ Details Needed for Approval *Please answer all questions and provide supporting documentation.*

- Which type of MS does the patient have? Circle one: CIS RRMS PPMS SPMS
- If the patient has PPMS, please provide all component scores of the Functional Systems Scale.
- Does the patient have a history or presence of elevated IgG index or at least 1 IgG oligoclonal band in CS fluid? _____
- For a patient starting on therapy, please provide documentation of all relapses within past 2 years.
- For a patient starting on therapy, have they been neurologically stable for the past 30 days? _____
- Does the patient have any other neurological disorders which may mimic multiple sclerosis? _____
- If the patient is being treated with another disease-modifying MS therapy, will it be discontinued prior to starting on therapy?
- Will the patient be receiving concomitant immunosuppressive therapy?
- Has the patient had a live or attenuated vaccine within the past 6 weeks?
- For a patient starting on therapy, provide negative results for HBsAg and anti-HBV.
- For a patient continuing on therapy, provide documentation of positive clinical response to therapy.
- Does the patient have either progressive multifocal leukoencephalopathy or active primary or secondary immunodeficiency?
- Provide MRI reports documenting status of current lesions and changes from prior scans.

■ Ocrevus IV Medication Order

- Premedicate Diphenhydramine 25mg by mouth 30-60 minutes prior, and methylprednisolone 100mg IV-push 30 minutes prior.
- Initial dose of Ocrevus (ocrelizumab) 300mg followed by a second dose of 300mg after 14 days +/- 1 day.
- Maintenance doses of Ocrevus (ocrelizumab) 600mg every 6 months for 1 year

Patient may take oral premeds at home and attest as such. Infusion administered through 0.2 micron filtered tubing. 300mg dose administered in 250ml of normal saline, 600mg dose administered in 500ml of normal saline. Follow the infusion rate tables published by Genentech. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms of an infusion reaction at start, throughout infusion, and after completion.

■ Ocrevus Zunovo SubQ Medication Order

- Premedicate with corticosteroid and antihistamine by mouth 30-60 minutes prior.
- Ocrevus Zunovo (ocrelizumab & hyaluronidase) 920mg every 6 months for 1 year.

Patient may take oral premeds at home and attest as such. Administer subcutaneously in abdomen over approximately 10 minutes according to the manufacturer's instructions. Post administration observe for at least 60 minutes for the first administration and at least 15 minutes for subsequent doses.

■ Rescue Management in Case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.