OCRELIZUMAB/OCRELIZUMAB HYALURONIDASE-OCSQ ORDERS (Ocrevus/Ocrevus Zunovo)

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ CMP/CBCw/diff/HepB/Quantitative immunoglobulins
☐ Documentation of contraceptive use (if applicable)
☐ Most recent MRI reports with documentation of any changes
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (855) 857-3834

SPECIALTY INFUSION CENTER — An Access Infusion Care Company

OCRELIZUMAB/OCRELIZUMAB HYALURONIDASE-OCSQ ORDERS (Ocrevus/Ocrevus Zunovo)

CENTERS AT SIC — An Access Infusion Care Managed Company

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change	
First dose? ☐ Yes ☐ No - Date of last infusion:	Line type (if applicable): ☐PIV ☐PICC ☐Port ☐Other:

DIAGNOSIS
☐ Dx Code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics and insurance info ☐ H&P, labs, tests, progress notes supporting dx	
MRI changes ☐Yes ☐No Date of last MRI:	☐TB Screening: ☐Positive ☐Negative-Date:
Documentation of contraceptive use (if applicable)	☐Hepatitis B Screening: ☐Positive ☐Negative-Date:
• Prior Therapies:	

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐CMP ☐CBCwdif ☐VitD ☐B12 ☐IgA,G,M ☐Lymphocyte subset panel ☐Other:

PREMEDICATIONS (administer 30-60 minutes prior to infusion, required per the PI))

Acetaminophen: ☐650mgPO ☐1000mgPO	Dexamethasone (Ocrevus Zunovo): ☐20mgPO
Diphenhydramine: ☐25mgPO ☐50mgPO ☐25mgIV ☐50mgIV	Cetirizine (Ocrevus Zunovo): ☐10mgPO
Methylprednisolone: ☐100mgIV ☐125mgIV ☐ mgIV	☐Other:

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☐**Ocrelizumab (Ocrevus)**	300mg/10mL	☐**Induction-300mg on day 1 and day 15** Infuse in 250ml 0.9%NS IV over 3.5 hours ☐**Maintenance-600mg every 6 months (starting 6 months from day 1)** Infuse in 500ml 0.9%NS IV over 3.5 hours (2 hours if no IRRs)	☐ 1 vial Refills: ☐ 2 vials Refills:
☐**Ocrelizumab/ Hyaluronidase-ocsq (Ocrevus Zunovo)**	920mg/23ml	☐**920mg every 6 months** Infuse subcutaneously over 10 minutes	☐ 1 vial Refills:

If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe patient for: Ocrevus-60 minutes/Ocrevus Zunovo-60 minutes for 1st infusion, 15 minutes for subsequent infusions

NURSING INSTRUCTIONS/EMERGENCY MEDICATION	
RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐**Product Substitution Permitted** ☐**Dispense as Written**

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