HOME PARENTERAL SERVICES

OCREVUS
(ocrelizumab)

PHONE: 1-800-637-9201
FAX: 1-417-269-0692

Patient Information

Patient name: _____ DOB: _____
Sex: ❑ Female ❑ Male SSN: _____
Language: _____ Wt: _____ ❑kg ❑lbs Ht: _____ ❑cm ❑in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ ___ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: G35 (Multiple Sclerosis) _____ Diagnosis Date: _____
Type: Clinically isolated syndrome Relapsing-remitting Secondary-progressive Primary-progressive Progressive-relapsing
Hepatic Impairment present: Yes No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____
Pre-existing hepatic conditions: HBV HCV _____ HBV Test: HBsAg+ HBcAb+ Both Negative Test date: _____
Has patient received an MS infusion product previously? Yes No
If yes, product information: _____ Date of last infusion: _____ Date of next infusion: _____

Prior Therapy ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

Flushing Orders:
• Per HPS protocol
PIV: 0.9% Sodium Chloride 3-20 ml before and after infusion as needed
Port : Bacteriostatic 0.9% Sodium Chloride 3-20ml into port at time of access or at least monthly, 0.9% Sodium Chloride 3-20 ml before and after infusion and as needed, Heparin 100units/ml 5ml as lock after infusion

Pre-Medication Orders:
❑ Diphenhydramine _____ mg PO 15-30 minutes prior to infusion
❑ Diphenhydramine _____ mg IV in 10ml NS 15-30 minutes prior to infusion
❑ Methylprednisolone _____ mg IV in NS 15-30 minutes prior to infusion
❑ Other: _____

Ocrevus (ocrelizumab):

Dose/Freq: ❑ Ocrevus 300mg IV on day 1 and day 15, then 600mg every 6 months, starting 6 months from day 1.
OR
❑ Ocrevus 600mg IV every 6 months

•Rate per manufacturers protocol
•Dilute 300mg in 250ml NS and 600mg in 500ml NS

Duration: Refills x 1 year OR _____ infusions

Note:
• Orders are initiated unless crossed out by provider

Prescriber's Signature: _____ _____ **Date:** _____
Substitution Permitted Dispense as Written

I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Home Parenteral Services.