CoxHealth at Home

OCREVUS
(ocrelizumab)

PHONE: 1-855-419-4663
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 CoxHealth at Home 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

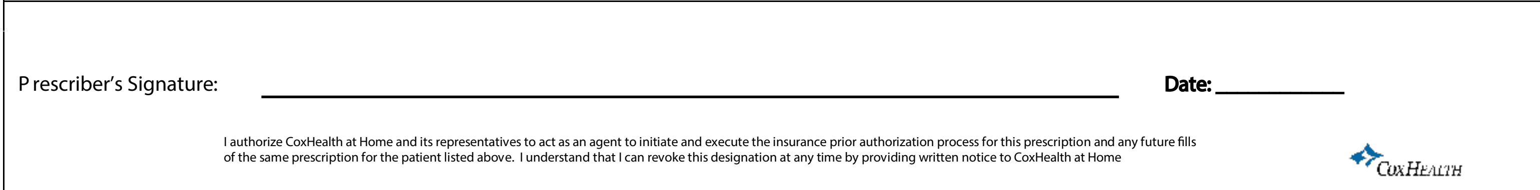
Pre-Medication Orders:
❑ Diphenhydramine ______ mg PO 15-30 minutes prior to infusion
❑ Diphenhydramine ______ mg IV in 10ml NS 15-30 minutes prior to infusion
❑ Methylprednisolone ______ mg IV in 10ml NS 15-30 minutes prior to infusion
❑ Other: ____

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:** ___________

I authorize CoxHealth at Home 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 CoxHealth at Home

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