INTEGRATED CARE SYSTEMS

OCREVUS®
PATIENT REFERRAL FORM

PHONE 800.734.2896
FAX 559.734.6451

Patient Last Name First Name	Referral Date
○ Male ○ Female DOB:	Prescriber
Weight _____ lbs **Height** _____ in	Provider Phone # Fax #
○ **NKDA** ○ **Allergies** _____	Nurse/Office Contact

PRIMARY DIAGNOSIS

○ Relapsing Multiple Sclerosis (MS) ***G35***

PHYSICIAN ORDER

○ Loading Dose

Ocrevus® 600 mg IV divided into 2 infusions
Administer 300 mg IV over 2.5-4 hours on 0 week and 2 weeks

○ Maintenance Dose

Ocrevus® 600 mg every 6 months
Administer 600 mg IV over 2-4 hours as tolerated
6 months after most recent infusion

Has patient received Ocrevus® before?
○ Yes
○ No

IV ACCESS
○ Port
○ Peripheral

○ Pre-medication
Acetaminophen 650mg PO 15-30 minutes before infusion
Diphenhydramine 25mg PO 15-30 minutes before infusion
Methylprednisolone 100 mg IV 15-30 minutes before infusion
Other _____

○ As Needed Meds
NS 1 liter IV daily over 4-6 hours
Ondansetron 8mg (add to NS bags for N/V)
Ondansetron 4mg IV push Q4-6 hours PRN N/V over 1-2 minutes

○ Anaphylactic Kit:
Epipen 0.3mg 2pk auto injector as directed
Diphenhydramine 12.5 mg tab #4
Diphenhydramine 50 mg/ml vial #2 as directed

○ Skilled nursing as needed for administration

PLEASE FAX THE FOLLOWING ALONG WITH THIS ORDER

-Face sheet/Demographics
-H&P
-Labs & Hepatitis B Screening Results
-Copy of Insurance Card
-MD Notes

We will notify you within 24 hours, once this referral is received

If you do not receive a confirmation please call 1.800.734.2896 or re-fax the referral to 559.734.6451

Thank you for the opportunity to assist in the care of your patient

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment

Physician Signature **Date**