FAX: 725.228.5220 eMediate INFUSION

OCREVUS

☐ New Prescription/Referral
☐ Prescription Refill

Of Refills:

PATIENT INFORMATION

*Patient Insurance & ID (front and back) are needed

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Ocrevus (ocrelizumab): (*Pre-Medications Required)

☐ Initial dose 300mg IV for 2.5 hrs
☐ 2nd dose 300mg IV for 2.5 hrs to be given after 2 weeks
☐ Other:_____

Ocrevus Zunovo: (ocrelizumab/ *hyaluronidase*) (*Premed protocol:)

☐ 920mg/23,000units subcutaneously every 6 months x1 year
☐ ***Dexamethasone (or equivalent corticosteroid):*** *20mg administered orally at least 30 mins prior to administration*
☐ ***Antihistamine (e.g., desloratadine):*** Administered orally at least 30 mins prior to administration to reduce the risk of local and systemic injection reactions
☐ ***Antipyretic (e.g., acetaminophen):*** The addition of an antipyretic may also be considered
☐ *Other:*_____

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg ☐ 1000mg
☐ Benadryl _____ mg PO
☐ 25 mg ☐ 50 mg
☐ IV ☐ PO
☐ Others: _____

ANA Kit Protocol:

☐ OK to use

Dx:

Diagnosis: _____

ICD-10: _____

PRESCRIBER SIGNATURE: x Date (Valid for 1 year):

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

Please include the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results
☐ Hep B Surf Ag (within 12 months) ☐ Serum Immunoglobulins ☐ CBC & CMP
☐ Hep B antigen & Hep B core total (within 12 months) ☐ MRI documentation

*If TB or Hep B results are positive - please provide documentation of treatment or medical clearance & a negative CXR (TB+)

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot