OCREVUS™ Infusion

OptiMed
Phone: 877.385.0535
Fax: 877.326.2856
6480 Technology Ave., Suite A | Kalamazoo, MI 49009

Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber ________________ **NPI** ________________

Phone ________________ **Fax** ________________ **Office Contact** ________________

Practice Name & Address ________________

Patient Information

Name ________________ **DOB** ________________ ☐**M** ☐**F**

Address ________________

Phone ________________ **2nd Phone** ________________ **SSN** ________________

Primary Language ________________ **Functional Limitations** ________________

Clinical Information

Diagnosis (include ICD-10 code) ________________

Weight ________ ☐lb ☐kg **Height** ________ ☐in **IV access** ☐PIV ☐PICC ☐Port ☐Other ________________

Patient's first dose? ☐Yes ☐No (Date of last dose: ________ Prior dose: ________) **Prior infusion reactions** ________________

HBV Screening Results HBsAg: ________ anti-HBV core antibody: ________ Date: ________________

Quantitative serum immunoglobulin (list results here and attach clinicals) ________________

Allergies ________________ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation ________________

____

History of kidney disease ☐Yes ☐No If yes, SCr: ________ GFR/CrCl: ________ **History of heart failure** ☐Yes ☐No

Prescription Information

Dosing Regimen	Quantity
☐ **Induction Dosing** Infuse OCREVUS™ 300mg in 250mL NaCl 0.9% at 0 and 2 weeks, then begin maintenance dosing. (Infusion rate to be titrated as per product package insert.)	2 doses (infusions)
☐ **Maintenance Dosing** Beginning 6 months from the first induction dose, infuse OCREVUS™ 600mg in 500mL NaCl 0.9% every 6 months. (Infusion rate to be titrated as per product package insert.)	_______ doses (infusions)

Nursing and Supplies Must be infused through a dedicated line using an infusion set with a 0.2 or 0.22 micron in-line filter. OptiMed to provide additional supply items and nursing care to prepare and administer product as per package instructions.

Premedication(s) [check to order]

☒ Methylprednisolone 100mg IV 30 minutes prior to OCREVUS™ infusion
☒ Diphenhydramine 50mg IV 30 minutes prior to OCREVUS™ infusion
☐ Famotidine 20mg IVP over 2 minutes 20-30 minutes prior to infusion
☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ Other ________________ Dose ________________
Route ________________ Frequency ________________

PRN medication orders [check to order]

☐ Famotidine 20mg IVP x1 PRN
☐ Other ________________ Dose ________________
Route ________________ Frequency ________________
☐ Other ________________ Dose ________________
Route ________________ Frequency ________________

Post-Infusion Patient to receive post-infusion monitoring and hydration with 500mL NaCl 0.9% infused over 60 minutes following each Ocrevus™ infusion.

Laboratory orders (subject to availability) List any outpatient laboratory work related to this therapy you would like OptiMed to draw in conjunction with the medication administration, including the frequency for each lab order. Lab orders are good for the life of the prescription order (one year) unless otherwise indicated. ________________

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: ________________ **Date:** ________________

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