


Ocrevus Prescription / Enrollment Form	SUPERIOR BIOLOGICS Fax Referral To: 914-747-1170 Phone: 855-747-1150	
Date: _____		

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Cell Phone: _____ Alternate Phone: _____ Date of Birth: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ DEA#: _____ NPI#: _____ Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)					
Primary Insurance: _____	ID#: _____	Group: _____	Secondary Insurance: _____	ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN: _____	PCN: _____	Group: _____	

DIAGNOSIS (ICD-10)	
<input type="checkbox"/> G35 Relapsing forms of Multiple Sclerosis (Clinically isolated syndrome/relapsing-remitting disease/active secondary progressive disease) <input type="checkbox"/> G35 Primary Progressive Multiple Sclerosis	

PRE-SCREENING	
<input type="checkbox"/> Hepatitis B Surface Antigen: _____ <input type="checkbox"/> Total Hepatitis B Core Antibody (Anti-HBc): _____ <input type="checkbox"/> Serum Immunoglobulins: _____ <input type="checkbox"/> Vaccination: _____ <small>(live or live-attenuated 4 weeks before, non-live 2 weeks before initiation of therapy)</small> Labs (During Therapy): _____	Vaccinations: Live-attenuated or live vaccines is not recommended during treatment and after discontinuation until B-cell repletion. Administer all necessary immunizations according to immunization guidelines at least 4 weeks prior to initiation for live or attenuated vaccines and at least 2 weeks prior to initiation for non-live vaccines. Pre-screening: Required Hepatitis screening before first dose to include: ____ Hepatitis B Surface Antigen (HBsAg) and Total Hepatitis B Core Antibody (anti-HBc) * Ocrevus® is contraindicated in patients with active HBV. Patients who are negative for surface antigen HBsAg (-) and positive for HB core antibody HBcAB (+) or positive for surface antigen HBsAg (+), should consult liver disease experts before starting and during treatment. ____ Quantitative Serum Immunoglobulin Screening (IgG, IgA, IgM)

PRESCRIPTION ORDERS	
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Premeds	
Premedication to be given 30 minutes prior to infusion: <input type="checkbox"/> Acetaminophen PO: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> Diphenhydramine: <input type="checkbox"/> 25mg IVP <input type="checkbox"/> 50mg IVP <input type="checkbox"/> 25mg PO <input type="checkbox"/> 50mg PO OR <input type="checkbox"/> Alternate oral antihistamine: <input type="checkbox"/> Cetirizine 10mg <input type="checkbox"/> Loratadine 10mg <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> 125mg IVP <input type="checkbox"/> 40mg IVP OR <input type="checkbox"/> _____mg PO <input type="checkbox"/> Fexofenadine 60mgs <input type="checkbox"/> Fexofenadine 180mgs <input type="checkbox"/> Others/Miscellaneous: _____ <input type="checkbox"/> Epinephrine pen Auto-Injector 2 pack 0.3mg/0.3ml IM as needed for anaphylaxis	

Medication	
Ocrevus (Ocrelizumab) IV as directed to infuse per protocol via pump with 0.22 µ [1.0cc] filter, following each infusion with a one hour post observation period. <input type="checkbox"/> Induction/Initial dosing: 300mg Ocrevus IV in 250ml Sodium Chloride 0.9% to be infused at Week 0 over 2.5 hours or longer and Week 2 over 3.5 hours or longer No Refills To be infused in MD office or an Infusion suite <input type="checkbox"/> Maintenance dosing: 600mg Ocrevus IV in 500ml Sodium Chloride 0.9% to be infused every 6 months over 2 hrs or longer <input type="checkbox"/> 3.5-4 hrs or longer Refills: <input type="checkbox"/> X1 year <input type="checkbox"/> Other: (Specify) _____ <input type="checkbox"/> P[{ ^ A Q ~ • q } A U ~ A T Ö A ~ A Infusions to be performed under the close supervision of a healthcare professional and to observe the patient for least one hour after completion of the infusion.	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)			
_____	_____	_____	_____
Dispense as Written	Date	Substitution Allowed	Date

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