Ocrevus Referral Form

Date: _____

SUPERIOR BIOLOGICS
Fax Referral To: 914-747-1170
Phone: 855-747-1150

SUPERIOR BIOLOGICS

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____
Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

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)

☐ G35 Relapsing forms of Multiple Sclerosis (Clinically isolated syndrome/relapsing-remitting disease/active secondary progressive disease)

☐ G35 Primary Progressive Multiple Sclerosis

PRE-SCREENING

☐ Hepatitis B Surface Antigen: _____
☐ Total Hepatitis B Core Antibody (Anti-HBc): _____
☐ Serum Immunoglobulins: _____ (IgG, IgA, IgM)

☐ Vaccination: _____ Height: _____ Weight: _____
Allergies: _____

(live or live-attenuated 4 weeks before, non-live 2 weeks before initiation of therapy)

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

Premeds

Premedication to be given 30 minutes prior to infusion:

☐ Acetaminophen PO: ☐ 325mg ☐ 500mg ☐ 650mg
Diphenhydramine: ☐ 25mg IVP ☐ 50mg IVP ☐ 25mg PO ☐ 50mg PO
OR ☐ Alternate oral antihistamine: ☐ Cetirizine 10mg ☐ Loratadine 10mg
☐ Fexofenadine 60mgs ☐ Fexofenadine 180mgs
IV Access Flush Order: NaCl 0.9% 5-10ml IV before and after infusion

☐ Methylprednisolone ☐ 125mg IVP ☐ 40mg IVP OR ☐ ____mg PO
☐ Others/Miscellaneous: _____

Anaphylaxis Orders and Medications

Diphenhydramine Administer 25 mg slow IV/IM may repeat x1 ***Dispense****: 1 x 50 mg vial*

Epinephrine Autoinjector ☐ Administer 0.15mg (1:2000) IM (< 30 Kg)
☐ Administer 0.3mg (1:1000) IM (≥ 30 Kg)
Dispense: 1 package (2 pens)

Sodium Chloride 0.9% *Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis*
Dispense*:* QS

Medication

Ocrevus (Ocrelizumab) IV as directed to infuse per protocol via pump with 0.22 µ or 0.2 Õfilter, following each infusion with a one hour post observation period.

☐ Induction/Initial dosing: 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 2 weeks later over 2.5 hours or longer. No Refills. ***To be infused in MD office or an Infusion suite.*

☐ Maintenance dosing: 600mg Ocrevus IV in 500ml Sodium Chloride 0.9% to be infused every 6 months. ☐ 2 hrs or longer for eligible patients who have not experienced a serious infusion reaction with any previous Ocrevus Infusion ☐ 3.5-4 hrs or longer. Refills: ☐ X1 year ***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.*

☐ Home ☐ Infusion Suite ☐ MD Office

By signing below, I certify that above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

_____ _____ _____ _____
Dispense as Written Date Substitution Allowed Date

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intend recipient, please notify us immediately.