

Ocrevus  
Referral Form

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



Date: \_\_\_\_\_

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.A Relapsing-remiting multiple sclerosis  
G35.B0 Primary progressive multiple sclerosis, unspecified  
Other: \_\_\_\_\_  
G35.C0 Secondary progressive multiple sclerosis  
G35.D\* Multiple sclerosis, unspecified

PRE-SCREENING

Hepatitis B Surface Antigen: \_\_\_\_\_  
 Total Hepatitis B Core Antibody (Anti-HBc): \_\_\_\_\_  
 Serum Immunoglobulins: \_\_\_\_\_

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:

Vaccination: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Allergies: \_\_\_\_\_

\_\_\_\_\_ 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)

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

Labs (During Therapy): \_\_\_\_\_

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 [ : A filter, 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.**

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

Dispense as Written

Date

Substitution Allowed

Date

Ocrevus Zunovo  
Referral Form

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**Dispense:** QS

Medication

Ocrevus Zunovo (Ocrelizumab/Hyaluronidase) SUBQ as directed to be infused per protocol by a healthcare professional. Patients monitored closely during all injections for at least one hour after the initial injection, and for at least 15 minutes after subsequent injections.

Administer 23 mL of Ocrevus Zunovo (920 mg ocrelizumab and 23,000 units hyaluronidase) SUBQ in the abdomen over 10 minutes every 6 months. **\*\*First dose to be infused in MD office or an Infusion Suite\*\***

Subsequent doses:

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