Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

Ocrevus (Ocrelizumab)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation
☐ Hepatitis B status & date (list results here & attach clinicals):
_____

Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Ocrevus induction.

☐ I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals):
_____
☐ I instruct AdaptIV Infusion to draw quantitative serum immunoglobulin prior to first induction infusion (if required by payor).

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ famotidine (Pepcid) 20mg PO
☐ methylprednisolone (Solu-Medrol) ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

THERAPY ADMINISTRATION

☐ **Ocrelizumab** (Ocrevus) intravenous infusion
☐ Induction:
- Dose: 300mg in 250ml 0.9% sodium chloride
- Frequency: on Day 1 and Day 15
- Rate: Start at 30ml/hr, increasing by 30ml/hr every 30 minutes to a maximum rate of 180ml/hr
- Duration should be at least 2.5 hours
- After induction, continue with maintenance dosing below

☐ Maintenance:
- Dose: 600mg in 500ml 0.9% sodium chloride
- Frequency: every 6 months from infusion 1 of initial dose

☐ Rate: (Choose one)
- ☐ Infuse over 3.5 hours (Start at 40ml/hr, increase by 40ml/hr every 30 minutes, max 200ml/hr)
- ☐ Infuse over 2 hours (Start at 100ml/hr x 15 min, 200ml/hr x 15 min, 250ml/hr x 30 min, 300ml/hr until completion)

NOTE: If rate not indicated and no prior serious infusion reaction with previous infusion, will infuse over 2 hours

☐ Flush with 0.9% sodium chloride at the completion of infusion
☐ Patient required to stay for 60-min observation post infusion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

* Hepatitis B virus and quantitative serum immunoglobulin screening are required before the first dose.
* Pre-medicate with methylprednisolone (or an equivalent corticosteroid) and an antihistamine (e.g., diphenhydramine) prior to each infusion.
* Monitor patients closely during and for at least one hour after infusion.

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK