Ocrelizumab (Ocrevus)

Provider Order Form rev. 08/06/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ G35: Multiple Sclerosis

Type: ☐ RRMS ☐ SPMS ☐ PPMS ☐ PRMS ☐ CIS

☐ Other: Description:

THERAPY ADMINISTRATION & DOSING

☐ Induction: Administer Ocrevus 300 mg IV in 250 ml 0.9% normal saline on Week 0 and Week 2 followed by 600mg IV in 500 ml 0.9% normal saline 6 months after initial dose

☐ Maintenance: Administer Ocrevus 600 mg IV in 500 ml 0.9% normal saline every 6 months

☑ Observe patient for hypersensitivity reaction for a period of 60 minutes following each infusion.

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC w/ diff ☐ at each dose ☐ every: _____

☐ Quantitative Serum Immune Globulin every 3 months

☐ Other: _____

PRE-MEDICATION ORDERS

☑ Tylenol 500mg

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☑ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☑ Solumedrol 125mg IVP

☐ Other: _____

NURSING

☑ Must have negative hepatitis B and TB test prior to start

☑ Hold infusion and notify provider for:

- Signs/symptoms of infection or planned/recent surgery.
- recent live vaccines
- pregnancy or neurological symptoms.

☑ Monitor vital signs with every rate change, then every 30 minutes and prior to discharge.

☑ Patients on maintenance dosing who have not experienced a serious infusion reaction with any previous Ocrevus infusion may be eligible for an increased infusion rate. Reference quick notes for specifics on eligibility and dosing rate table.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, MRI results, Lesion number

Required Labs: Negative Hepatitis B

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.