Ocrelizumab (Ocrevus)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

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

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• Hepatitis B results: If Hepatitis B results are positive, provide documentation of medical clearance

• Quantitative serum immunoglobulin screening • Liver Function Tests

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ G35.A Relapsing-remitting multiple sclerosis ☐ G35.B0 Primary progressive multiple sclerosis, unspecified

☐ G35.B1 Active primary progressive multiple sclerosis ☐ G35.B2 Non-active primary progressive multiple sclerosis

☐ G35.C0 Secondary progressive multiple sclerosis, unspecified ☐ G35.C1 Active secondary progressive multiple sclerosis

☐ G35.C2 Non-active secondary progressive multiple sclerosis ☐ G35.D Multiple sclerosis, unspecified ☐ Other:

PRIMARY MEDICATION ORDER

Ocrelizumab (Ocrevus) intravenous infusion

• Flush with 0.9% sodium chloride at the completion of infusion
• Patient required to stay for 60-min observation post infusion
• Refill for 12 months unless otherwise noted: _____

☐ ***New Start:*** 300mg in 250ml 0.9% Sodium chloride on Day 1 & Day 15, then 600mg in 500ml 0.9% Sodium chloride every 6 months

☐ ***Maintenance:*** 600mg in 500ml 0.9% Sodium chloride every 6 months

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ acetaminophen (Tylenol) ☑ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☑ famotidine (Pepcid) 20 mg IV
☑ diphenhydramine (Benadryl) ☑ 25mg / ☐ 50mg ☑ PO / ☐ IV
☑ methylprednisolone (Solu-Medrol) ☐ 40mg / ☑ 125mg IV
☐ Other: _____
Dose: _____ Route: _____

LABORATORY ORDERS

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

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772
☐ Arbor Infusion Carmel (317) 981-1772