

Ocrelizumab (Ocrevus)

Provider Order Form rev. 8/24/26



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