

1 PATIENT INFORMATION Patient Name: _____ Phone: _____ Address: _____ MRN #: _____ DOB: _____ Drug Allergies: _____	2 PRESCRIBER INFORMATION Prescriber's Name: _____ DEA#: _____ NPI: _____ Clinic/Facility Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____
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3 Instructions to Provider
 All orders with will be placed unless otherwise noted. Please fax completed order form to 206-326-2139. For drug prior authorization, call 1-888-767-4670 or visit <https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice>.

4 CLINICAL INFORMATION
 Diagnosis (ICD-10 code): _____ Date of Last Dose: _____

5 OCREVUS MAINTAINENCE PRESCRIPTION INFORMATION

ocrelizumab (OCREVUS) in 0.9% sodium chloride 250 mL IV infusion Weight: _____ lbs kg Date Recorded: _____
First Dose: No Yes, first two doses must be given in Infusion Center
Dose: 300 mg 600 mg **Frequency (maintenance):** Every 6 months
Refills: 11 months Other _____
Infusion Access: PIV CVAD Other: _____
Infusion Rates, and Supplies: Per protocol (See below) Special Instructions (Specify below)
Patient's Current Home Care/Specialty Pharmacy: _____

Infusion Reaction Medications & Supplies

- | | |
|---|--|
| <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Hydrocortisone sodium succinate injectable 100 mg IV
Sig: Once PRN for hypersensitivity <input checked="" type="checkbox"/> Epinephrine Auto-Injector <input type="checkbox"/> 0.15mg <input type="checkbox"/> 0.3mg QTY: 2
Sig: Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use. <input checked="" type="checkbox"/> Sodium Chloride 0.9% IV Flush: Flush 10 ml IV before/after medication administration or as needed for line maintenance | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Diphenhydramine injectable 25 mg IV
Sig: Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath <input checked="" type="checkbox"/> Sodium Chloride 0.9% IV 250ml Bag
Sig: Once PRN for anaphylaxis |
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Labs /Special Instructions/Pre-meds: _____

Ocrevus Infusion Protocol:

- Infuse per manufacturer guidelines
- Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4; then every 30 minutes x2; then every 60 minutes until completion of infusion
- Documentation must include:
 - Start and end time of infusion
 - All rate changes, vital signs, including initial and final set
 - Patient response

- Observe patient for signs of infusion rate-related adverse reactions:

- Blood pressure changes, increased pulse rate
- Fever, chills
- Headache
- Chest, back or hip pain
- Dyspnea
- Mild erythema

6 PHYSICIAN SIGNATURE REQUIRED	
X _____ SUBSTITUTION PERMITTED (Date)	X _____ DISPENSE AS WRITTEN (Date)

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