**Cumberland Vital Care**

**Fax Referral To: (931) 456-4857**

**Direct Phone: (931) 456-0680**

# OCREVUS ORDER FORM

Date: ______________________ ICD-10 Code: ______________________

Patient Name: ______________________ Allergies: ______________________

Date of Birth: ______________________ Weight: ________lbs OR ________ kg

**Therapy Status**

☐ New Start

☐ Continuing Therapy:
Last Dose: ______________________

## PROVIDER INFORMATION

Ordering Provider: ______________________ Provider Fax: ______________________

Provider NPI: ______________________ Provider Address: ______________________

Provider Phone: ______________________

## MEDICATION ORDER

**Ocrevus**

☐ Initiation: Infuse Ocrevus 300mg IV per protocol on Day 1 and Day 15.

☐ Maintenancee: Infuse Ocrevus 600mg IV every six months. If first maintenance dose, schedule six months from Day 1 of initiation phase.

✓ Pre-medications will be given as indicated below unless otherwise specified. Antihistamine dosage and route to be determined by on site provider.

✓ If no history of infusion reaction with any Orevus infusion, maintenance doses may be infused using titrated rates over two hours.

Refills x one year from date of signature unless indicated below.

☐ ________ Refills

***Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:***

✓ Hepatitis B Surface Antigen

✓ Hepatitis B Core Antibody Total (Not Core IgM)

✓ Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment)

## PRE-MEDICATIONS

***Oral***

✓ Acetaminophen: ______325mg ______500mg ___X___650mg

☐ Loratadine: 10mg

☐ Cetirizine: 10mg

✓ Diphenhydramine: ______25mg ______50mg

☐ Famotidine: ______20mg ______40mg

☐ Ibuprofen: ______200mg ______400mg ______600mg

☐ Ondansetron: ______4mg ______8mg

☐ Other: ______________________

***IV***

☐ Dexamethasone: ______4mg ______8mg

✓ Diphenhydramine: ______25mg ______50mg

☐ Famotidine: ______20mg ______40mg

✓ Methylprednisolone: ___X___125mg

☐ Hydrocortisone: 100mg

☐ Ondansetron: ______4mg ______8mg

☐ Other: ______________________

## LAB ORDERS (please indicate any labs to be drawn and frequency)

**Surveillance lab ordering and monitoring is the responsibility of the prescriber**

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Ofice Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

______________________ ______________
Prescriber Name Date

Substitution Allowed:

______________________ ______________
Prescriber Name Date

V 9.28.23

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