MS-Ocrevus Enrollment Form

Phone: 855-497-7956 **Fax:** 844-486-2186

Ship To: Patient Physician Other **Ship By:** _____

Patient Information

Name: _____

DOB: _____ Gender: M F SSN: _____

Language: Eng Span Other:_____ Weight: _____ Lbs Kgs

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____

Allergies: _____ NKDA

Prescriber Information

Prescriber: _____

DEA: _____ NPI: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Cell #: _____ Fax #: _____

Office Contact: _____

Initiate Appeal Reason: _____

**** INSURANCE INFORMATION: PLEASE FAX COPY OF PRESCRIPTION CARD, FRONT AND BACK AS WELL AS ALL CLINIC NOTES ****

Clinical Information

DIAGNOSIS: G35 Multiple Sclerosis Other ICD 10 Code and Description _____

Date of Diagnosis _____ | Number of Relapses in Past Year _____ | Date of Last MRI_____ Changes Yes No

Lab Data _____

Current Medications _____

Nursing Training Patient Home Clinic MD Office

Prior Failed Medications	Length of Treatment	Reason for Discontinuing

Medication

The patient tested negative for Hepatitis B on ___/___/____

Ocrevus Infusion Protocol **Do NOT mix Ocrevus with NS prior to obtaining IV access**

Premedication to be given 30 minutes prior to each infusion:

a) Methylprednisolone 100 mg IV Push b) Diphenhydramine 25 mg po c) _____

Start IV with NS flush 3-5 mL IV pre/post/prn Dispense 10 mL Qty: QS, Refill prn x 1 year

Administer diluted infusion through an infusion set with a 0.2 or 0.22 micron filter

☐ **Initial Dose:**

Mix Ocrevus 300 mg/10 mL in NS 250 mL & infuse IV over at least 2.5 hours on Day 1 and Day 15; Dispense 300 mg #2

Start at 30 mL/hr for 30 minutes; increase rate by 30 mL/hr Q 30 min until max rate of 180 mL/hr reached

Start:	at 30 min:	at 60 min:	at 90 min:	at 120 min:	at 150 min:
30 mL/hr	60 mL/hr	90 mL/hr	120 mL/hr	150 mL/hr	180 mL/hr

☐ **Maintenance Dose:**

Mix Ocrevus 600 mg/20 mL in NS 500 mL & infuse IV over at least 3.5 hours every 6 months; Dispense 300 mg #2 Refill: 1

Start at 40 mL/hr for 60 minutes; increase rate by 40 mL/hr Q 30 min until max rate of 200 mL/hr reached

Start:	at 30 min:	at 60 min:	at 90 min:	at 120 min:
40 mL/hr	80 mL/hr	120 mL/hr	160 mL/hr	200 mL/hr

Observe the patient for 1 hour after the completion of each infusion.

Anakit: Diphenhydramine 25 mg po #1 & 50 mg/mL IV #1; Epinephrine 1 mg/mL #1 amp; NS 500 mL #1; UD prn anaphylaxis

Additional Information

Prescriber Signature: _____ **Date:** _____

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing BioCure LLC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-pay Assistance Foundations