# Checklist for Ocrevus / Ocrevus Zunovo (ocrelizumab) Referral

**Patient Name:** _____ **DOB:** _____ **Date:** _____

**Referring Physician:** _____**NPI:** _____

**Office Contact/Title/Email:** _____

**Office Address:** _____

**Office Phone:** _____ **Office Fax:** _____

**Best contact number for physician in case of reaction:** _____

*Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.*

- ❑ Patient demographic information
- ❑ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ❑ Supporting clinical notes and office visits. Two notes preferred.
    - Note should include any therapies tried/failed, and must include discussion about Ocrevus
    - Medication list and allergies
    - Last Ocrevus infusion note, if available
- ❑ Supporting lab reports/orders for Ocrevus treatment
    - Baseline: CBC w diff, CMP, serum immunoglobulins, Hepatitis B screening, and brain MRI within 1 year
    - *For continued therapy:* CBC w diff and CMP prior to each infusion
    - Ensure all vaccinations are up to date prior to treatment. Live vaccines should be given at least 4 weeks prior to treatment, and non-live vaccines should be given at least 2 weeks prior to treatment.
- ❑ Ocrevus Prescribing Order (see attached)

**-- We will obtain prior authorization and schedule your patient as soon as possible –**

---

## Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

---

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterne.com

**Infusion Center of New England**
18 Washington Street, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

# Prescribing Order: Ocrevus / Ocrevus Zunovo (ocrelizumab)

**Date of Order:** _____ ❑ New Start ❑ Maintenance
Date of last infusion: _____

**Patient Name:** _____ **DOB:** _____ **M/F:** ____

**Diagnosis (include ICD-10 code/s):** _____

❑ **NKDA** **Allergies:** _____

Patient Weight: _____

**Premedication:**

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Diphenhydramine 25mg IV
❑ Solu-medrol 125mg IV in 50ml over 15min
❑ Other: _____

**Lab Orders:**

❑ CBC w/diff, CMP every _____ weeks
❑ Other: _____
_____

**Ocrevus Medication Order:**

❑ **Ocrevus 300mg IV on Day 1 and Day 15.** *Begin infusion at 30ml/hr and increase by 30ml/hr every 30min to a maximum rate of 180ml/hr.*
❑ **Ocrevus 600mg IV once every 6 months.** *Begin infusion at 40ml/hr then increase rate by 40ml/hr every 30 minutes to a maximum rate of 200ml/hr until completion.*
❑ **Shorter Infusion Time: Ocrevus 600mg IV once every 6 months.** *Begin infusion at 100ml/hr for the first 15 min, increase to 200ml/hr for the next 15 min, increase to 250ml/hr for the next 30 min, then increase to 300ml/hr for the remaining 60 min.*
❑ **Ocrevus Zunovo 920mg/23ml SC every 6 months.** *Infuse subcutaneously in the abdomen over approximately 10 minutes.*

✓ Post infusion observation: Required for 1 hour after all Ocrevus IV treatments and first Ocrevus Zunovo SC treatment
  ❑ NS 100ml/hr x 1 hour

**Administration:**

✓ Vital Signs: Pre-treatment, at every rate change, and post-treatment
✓ Do not administer if patient has signs or symptoms of active infection
✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

**Ordering Provider Name** **NPI**

**Signature** **Date**

**Infusion Center of New England**
18 Washington Street, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671