Ascension at Home | TOGETHER WITH COMPASSUS®

OCREVUS INFUSION ORDERS

P: 800-648-8055 | F: 414-563-0600

PATIENT INFORMATION:

Fax completed form, insurance information and clinical documentation to 414-563-0600

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ❒ New to Therapy ❒ Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Diagnosis: Multiple Sclerosis

Type: ❒ Relapsing-Remitting ❒ Primary-Progressive ❒ Secondary-Progressive ❒ Clinically Isolated

ICD-10 Code: G35

Patient Weight: _____lbs. (required) Allergies: _____

THERAPY ORDER

Ocrevus:

❒ Loading Dose: 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x 1 year

❒ 600mg IV every 6 months x 1 year

Protocol Pre-medication Orders: Solu-Medrol 100mg IV and Benadryl 25 mg PO 30 minutes before infusion

Additional Pre-medication Orders: _____

Lab Orders: _____ **Lab Frequency:** _____

Other orders: _____

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or SQ; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen jr. 0.15mg or compounded or compounded syringe IM or SQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- Famotidine 20 mg IV as needed (adult)
- NS 0.9% 500mL IV bolus as needed (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION:

By signing this form and utilizing our services, you are authorizing *Ascension at Home Together with Compassus* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Patient Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

❒ Opt out of AAH together with Compassus selecting Site of care (if checked, please list site of care) _____

PREFERRED LOCATION:

City: _____ State: _____

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COMPREHENSIVE SUPPORT FOR OCREVUS THERAPY

P: 800-648-8055 | F: 414-563-0600

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ❒ Include signed and completed order (MD/prescriber to complete page 1)
- ❒ Include patient demographic information and insurance information
- ❒ Include patient's medication list
- ❒ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ❒ Expanded Disability Status Scale (EDSS) score:_____
  - ❒ Include labs and/or test results to support diagnosis
    - ❒ MRI
- ❒ *If applicable* - Last know biological therapy: _____*and last date received:* _____
  If patient is switching to biologic therapies, please perform a wash-out period of _____ *weeks prior to starting Ocrevus.*
- ❒ *Other medical necessity:*_____

REQUIRED PRE-SCREENING

- ❒ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - attach results**
  - ❒ **Positive** ❒ **Negative**

*If Hepatitis B results are positive - please provide documentation of treatment or medical clearance

- ❒ **Quantitative serum immunoglobulin**

Ascension at Home together with Compassus will complete insurance verification and submit all the required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if an additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to 414-563-0600 or call 800-648-8055 for assistance

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