CSI CLINICAL SPECIALTY INFUSIONS

Phone: 833-569-1005 | Fax: 430-200-4889 | Online: deliver.myforcura.com

OCREVUS / OCREVUS ZUNOVO ENROLLMENT FORM

Account manager: _____ Contact info: _____

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		Caregiver (if applicable):	
Address:	City:	State:	Zip:
Main Phone:	Alternate Phone:	Email:	Last 4 of SSN (required):
Date of Birth:	☐ Male or ☐ Female	Height (required): _____ ☐ cm or ☐ inches	Weight (required): _____ ☐ lb or ☐ kg

CLINICAL INFORMATION

Primary ICD-10 Code: ☐ RRMS ☐ PPMS	Is patient currently on therapy? ☐ Yes ☐ No
Previous tried/failed therapies:	Allergies:
Is this a female patient of childbearing age? ☐ Yes ☐ No	**REQUIRED:** Has the patient been tested NEGATIVE for HepB? ☐ Yes ☐ No ☐ Pending Result:_____ Test Date: _____
RECOMMENDED: Has the patient been tested for JCV antibodies? ☐ Yes ☐ No ☐ Pending Result:_____ Test Date: _____	

PRESCRIPTION AND ORDERS

Medication	Dosing		Quantity	Refills
☐ **Ocrevus®** (Adult MS)	**Premedication 30 minutes prior to each Ocrevus:** (refill x1 year) ☐ Methylprednisolone 100 mg IV push, dispense x1 dose (refill x1 year) ☐ Diphenhydramine 25-50 mg PO or IV push, PO dispense x1 bottle (refill x1 year) or IV dispense x1 (refill x1 year) ☐ Acetaminophen 500-1000 mg PO, dispense x1 bottle (refill x1 year) **Induction:** ☐ 300 mg IV at week 0 and week 2	**Maintenance:** ☐ 600 mg IV every 6 months ☐ Other: _____	☐ 2 doses for induction ☐ 1 dose every 6 months for maintenance	x1 year unless noted otherwise: ☐ No refills
☐ **Ocrevus Zunovo™** (Adult MS)	**Premedication 30 minutes prior to each Ocrevus:** (refill x1 year) ☐ Dexamethasone 20 mg PO or equivalent PO corticosteroid, dispense x1 dose (refill x1 year) ☐ Diphenhydramine 25-50 mg PO, dispense x1 bottle (refill x1 year) ☐ Acetaminophen 500-1000 mg PO, dispense x1 bottle (refill x1 year) **Induction:** No initial doses required	**Maintenance:** ☐ 920 mg/23,000 units SUBQ every 6 months ☐ Other:	☐ 1 dose every 6 months	x1 year unless noted otherwise: ☐ No refills

Medication Specific Infusion and Administration:
Ocrevus® IV - DOSE 1 and 2: Infuse over at least 2.5 hours: Start at 30 mL/hr; May increase by 30 mL/hr every 30 minutes to a max of 180 mL/hr. **MAINTENANCE DOSES:** Infuse over at least 3.5 hours; Start at 40 mL/hr; May increase by 40 mL/hr every 30 minutes to a max rate of 200 mL/hr.
Ocrevus Zunovo™ SUBQ - Administer SUBQ over 10 minutes.

Labs obtained 1-2 weeks prior to infusion:
Ocrevus: CBC w/ differential, IgA, IgG, and IgM every 6 months.
Ocrevus Zunovo: CBC w/ differential, IgA, IgG, and IgM drawn prior to first infusion as baseline, and every 6 months.

Flush Orders (Ocrevus Infusions ONLY): Flush with 0.9% sodium chloride 5-10 mL pre and post medication and as needed, max per dispense x 60 syringes (refill x1 year). ONLY if CVAD, add Heparin 100 units/mL 3-5 mL to flush after final saline flush to maintain line patency as needed, max per dispense x 30 syringes (refill x1 year).

Supplies: Dispense ancillary supplies, including ambulatory infusion pump (Ocrevus ONLY), as needed to provide home infusion therapy.

PRN: ☐ Lidocaine/Prilocaine 2.5% apply to site of injection as needed for numbing effect. Remove prior to injection, dispense 30 g tube (refill x1 year)	**Ocrevus Zunovo Adverse/ Anaphylactic Reactions, per protocol (Subcutaneous):** • Epinephrine autoinjector 0.3 mg IM as directed PRN for anaphylaxis, dispense 2pk x 1 (refill x 1 year)	**Ocrevus Adverse/Anaphylactic Reactions, per protocol (Intravenous):** dispense ana-kit x 1 (refill x 1 year) • Epinephrine 1:1000, 1 mL vial x 1 • Diphenhydramine 50 mg/1 mL vial x1 • Diphenhydramine 50 mg tab/cap x1 • 0.9% Sodium Chloride 500 mL bag x1

Nursing Orders for Home Infusion: Provide skilled nursing for home medication administration as prescribed and per CSI nursing policies. Insert, access, and manage vascular access devices. Deliver nursing care for therapy duration and educate patient on medication, disease state, adverse reactions, and administration. Monitor patient response and report adverse events.

PRESCRIBER INFORMATION

Prescriber Name:		Practice site name:	
Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	
Office contact and special instructions:			

Prescriber Authorization: I authorize the pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: **Date:**