

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, dispense x1 bottle (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 Zunovo: (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
Briumvi® (Adult MS)	Premedication 30 minutes prior to each Brriumvi: (refill x1 year) Methylprednisolone 100 mg IV push, 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: 150 mg IV at week 0 and 450 mg IV at week 2	Maintenance: 450 mg IV every 24 weeks (starting from date of 1st dose) Other: _____	2 doses for induction (150 mg and 450 mg dose) 1 dose every 24 weeks for maintenance	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. Briumvi IV - 1st infusion: Begin at rate of 10 mL/hr for 30 min. If tolerated, may increase to 20 mL/hr for 30 min, then 35 mL/hr for 60 min. If tolerated, may increase to 100 mL/hr for the remaining 2 hours. Subsequent Infusions: Begin at rate of 100 mL/hr for 30 min if 1st infusion rate tolerated well. May increase to 400 mL/hr for the remaining 30 min.				
Labs obtained 1-2 weeks prior to infusion: Ocrevus: CBC w/ differential, IgA, IgG, IgM, and Hepatic Function Panel every 6 months. Ocrevus Zunovo: CBC w/ differential, IgA, IgG, IgM, and Hepatic Function Panel drawn prior to first infusion as baseline, and every 6 months.				
Flush Orders (IV 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 3-5 mL to flush after final saline flush to maintain line patency as needed, PORT 100 units/mL; PICC 10 units/mL, max per dispense x 30 syringes (refill x 1 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 x1 (refill x 1 year)		Ocrevus and Brriumvi Infusion Adverse/Anaphylactic Reactions, per protocol (Intravenous): dispense ana-kit x1 (refill x1 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:	