CSI CLINICAL SPECIALTY INFUSIONS

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

OCREVUS / OCREVUS ZUNOVO / BRIUMVI 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 x 1 year) ☐ Methylprednisolone 100 mg IV push, dispense x 1 dose (refill x 1 year) ☐ Diphenhydramine 25-50 mg PO, dispense x 1 bottle (refill x 1 year) ☐ Acetaminophen 500-1000 mg PO, dispense x 1 bottle (refill x 1 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	x 1 year unless noted otherwise: ☐ No refills
☐ **Ocrevus Zunovo™** (Adult MS)	**Premedication 30 minutes prior to each Ocrevus Zunovo:** (refill x 1 year) ☐ Dexamethasone 20 mg PO or equivalent PO corticosteroid, dispense x 1 dose (refill x 1 year) ☐ Diphenhydramine 25-50 mg PO, dispense x 1 bottle (refill x 1 year) ☐ Acetaminophen 500-1000 mg PO, dispense x 1 bottle (refill x 1 year) **Induction:** No initial doses required	**Maintenance:** ☐ 920 mg/23,000 units SUBQ every 6 months ☐ Other: _____	☐ 1 dose every 6 months	x 1 year unless noted otherwise: ☐ No refills
☐ **Briumvi®** (Adult MS)	**Premedication 30 minutes prior to each Briumvi:** (refill x 1 year) ☐ Methylprednisolone 100 mg IV push, dispense x 1 dose (refill x 1 year) ☐ Diphenhydramine 25-50 mg PO, dispense x 1 bottle (refill x 1 year) ☐ Acetaminophen 500-1000 mg PO, dispense x 1 bottle (refill x 1 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	x 1 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: CSI to draw baseline CBC w/ differential, IgG, IgA, IgM, and Hepatic Function Panel labs if none present in clinical documentation on referral, and repeat labs at each infusion visit 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 x 1 year). For CVADs ONLY, may add Heparin 3-5 mL as final flush to maintain 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 (IV infusions 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 x 1 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 and Briumvi Infusion 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 x 1
- Diphenhydramine 50 mg tab/cap x 1
- 0.9% Sodium Chloride 500 mL bag x 1

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:**