



OCREVUS REFERRAL FORM

PATIENT DEMOGRAPHICS:			
PATIENT NAME:		PATIENT'S CONTACT #:	
DATE OF REFERRAL:		ADDRESS:	
DATE OF BIRTH:		CITY, STATE, ZIP:	
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:			
HEIGHT: _____ FEET	_____ INCHES	GENDER: FEMALE	MALE
WEIGHT: _____ LB	or _____ KG	ALLERGIES: SEE LIST	NKDA
PRIMARY DIAGNOSIS:			
G35 - Multiple sclerosis		Other	
REQUIRED DOCUMENTATION: Please provide a copy of the following documents.			
<input checked="" type="checkbox"/> 1. INSURANCE CARD (Front & Back) <input checked="" type="checkbox"/> 2. PATIENT DEMOGRAPHICS <input checked="" type="checkbox"/> 3. MOST RECENT LABS <input checked="" type="checkbox"/> 4. MEDICATION LIST			
<input checked="" type="checkbox"/> 5. H & P <input checked="" type="checkbox"/> 6. MRI RESULTS <input checked="" type="checkbox"/> 7. NEGATIVE HEPATITIS B, SEROLOGY <input checked="" type="checkbox"/> 8. IMMUNOGLOBULINS PANEL			
PRIMARY MEDICATION ORDER:		PRN & PREMEDICATIONS:	
Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy.		MEDICATIONS	30 minutes prior to every infusion
Loading Dose: Ocrevus 300 mg IV on day 1 and day 15.		Acetaminophen 650 mg PO	PRN every ___ hour for mild or moderate infusion reaction.
Maintenance Dose: Ocrevus 600 IV mg every 6 months.		Diphenhydramine 25 mg PO	PRN every ___ hour for mild or moderate infusion reaction.
Other:		Diphenhydramine 25 mg IV	PRN every ___ hour for mild or moderate infusion reaction.
		Methylprednisolone 125 mg IV	PRN every ___ hour for mild or moderate infusion reaction.
FIRST DOSE: Y N		Other: _____	PRN every ___ hour for mild or moderate infusion reaction.
<input checked="" type="checkbox"/> Refill x12 months unless otherwise noted.			
LINE USE/CARE ORDERS:		ADVERSE REACTION & ANAPHYLAXIS ORDERS:	
<input checked="" type="checkbox"/> START PIV/ACCESS CVC <input checked="" type="checkbox"/> FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (SEE REVERSE SIDE) OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)		<input checked="" type="checkbox"/> ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side) OTHER: (please fax other reaction orders if checking this box)	
PRESCRIBER INFORMATION: Please check preferred form of communication.			
PROVIDER NAME:		PHONE:	
OFFICE CONTACT:		FAX:	
ADDRESS:		EMAIL:	
CITY, STATE, ZIP:		NPI:	
 (GENERIC SUBSTITUTION PERMITTED) PROVIDER SIGNATURE:		DATE:	
 (DISPENSE AS WRITTEN) PROVIDER SIGNATURE:		DATE:	

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FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	<ul style="list-style-type: none"> Flushing Dizziness Headache Apprehension Diaphoresis Palpitations Nausea / Vomiting Pruitis 	<ul style="list-style-type: none"> Chest Tightness Shortness of Breath Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) Increased Temperature (>2 Degrees Fahrenheit) Urticaria 	<ul style="list-style-type: none"> Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). Increase Temperature (>2 Degrees Fahrenheit) with Rigors Shortness of Breath with Wheezing Laryngeal Edema Chest Pain Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.