PARAGON HEALTHCARE

OCRELIZUMAB ORDER SET

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: ______________________ DOB: __________ Phone: ______________

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: Multiple Sclerosis **ICD-10 Code**: G35

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

Patient Weight: _______ lbs. (required) Allergies: ______________________

THERAPY ORDER

Ocrevus (ocrelizumab) IV:

☐ Initial start: 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 IV Pre-medication Orders: Solu-Medrol 100mg IV and diphenhydramine 25mg PO 30 minutes before infusion

Substitute diphenhydramine with:

☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Cetirizine 10mg IV

Ocrevus Zunovo (ocrelizumab/hyaluronidase):

☐ 920mg/23,000units subcutaneously every 6 months x 1 year

Protocol SubQ Pre-medication Orders: dexamethasone 20mg PO & cetirizine 10mg PO 30 minutes before injection

Other orders: ______________________

Lab Orders: ______________________ **Lab Frequency:** ______________

Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

Home IV Biologic Ana-kit Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- NS 0.9% 1000mL IV bolus PRN per protocol (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

Home biologic injection Ana-kit (adult): EpiPen 0.3mg IM (2-pack)

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* 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.

Provider Name: ______________ Signature: ______________ Date: ________

Provider NPI: __________ Phone: __________ Fax: __________ Contact Person: __________

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: ______________ State: ________ *View our locations here:*

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

PARAGON
HEALTHCARE

COMPREHENSIVE SUPPORT FOR OCREVUS THERAPY

PATIENT INFORMATION:

Patient Name: ______________________________ DOB: ____________

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & 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 therapy

- ☐ Expanded Disability Status Scale (EDSS) score: ____________

☐ Include labs and/or test results to support diagnosis

- ☐ MRI

☐ *If applicable* - Last known biological therapy: ________________ and last date received: ________________. If patient is switching biologic therapies, please perform a wash-out period of ____________ weeks prior to starting ocrelizumab.

☐ 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

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any 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 (855) 889-2946 or call (877) 365-5566 for assistance

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