PARAGON HEALTHCARE

A Carelon Company

OCREVUS (OCRELIZUMAB) INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:		ZIP:
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:			Email:
Address:		City: State:	ZIP:
NPI #:	DEA#:		Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Ocrevus (ocrelizumab)	☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months ☐ 600mg IV every 6 months Pre-medication Orders: Solu-Medrol 100mg IV and diphenhydramine 25mg PO 30 minutes before infusion (if no contraindications) Substitute diphenhydramine with: ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Cetirizine 10mg IV	☐ x 1 year ☐ _____
Ocrevus Zunovo (ocrelizumab/ hyaluronidase)	☐ 920mg/23,000units subcutaneously every 6 months Pre-medication Orders: dexamethasone 20mg PO and cetirizine 10mg PO 30 minutes before injection (if no contraindications)	☐ x 1 year ☐ _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____
Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

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.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR OCREVUS (OCRELIZUMAB) THERAPY

PATIENT INFORMATION

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

☐ **Liver function tests including bilirubin**