Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Ocrevus (ocrelizumab) Treatment Plan

Patient Name: _____ **Patient DOB** _____

General

☐ Diagnosis- _____ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Authorized Treatment Duration ☐ 12 Months ☐ Other _____

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)
every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP every 30 minutes during the infusion and prior to discharge

Pre- Treatment Medications (Note: Pre-treatment with acetaminophen oral, diphenhydramine IV push, and methylprednisolone IV push recommended prior to infusion)

Acetaminophen (Month 1 to 12)

☐ *1000 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before dose

Diphenhydramine (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

Methylprednisolone (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before infliximab dose

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before infliximab dose

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Ocrevus (ocrelizumab) Treatment Plan

Loading Dose Ocrelizumab

☐ *300 mg, IV Piggyback, Injection, **Once***
Comments: 300 mg dose: Begin infusion at 30 mL/hour; increase by 30 mL/hour every 30 minutes to a maximum rate of 180 mL/hour. Infusion duration is 2.5 hours or longer. Monitor for infusion reactions during infusion and observe for at least one hour after infusion is complete. If infusion reaction occurs, interrupt infusion, discontinue or decrease the rate, depending on the severity of the reaction and contact provider

☐ *300 mg, IV Piggyback, Injection, 2 doses on **Day 1 and day 14***
Comments: 300 mg dose: Begin infusion at 30 mL/hour; increase by 30 mL/hour every 30 minutes to a maximum rate of 180 mL/hour. Infusion duration is 2.5 hours or longer. Monitor for infusion reactions during infusion and observe for at least one hour after infusion is complete. If infusion reaction occurs, interrupt infusion, discontinue or decrease the rate, depending on the severity of the reaction and contact provider

Maintenance Dose Ocrelizumab

☐ *600 mg, IV Piggyback, Injection, **Once***
Comments: 600 mg dose: Begin infusion at 40 mL/hour; increase by 40 mL/hour every 30 minutes to a maximum rate of 200 mL/hour. Infusion duration is 3.5 hours or longer Monitor for infusion reactions during infusion and observe for at least one hour after infusion is complete. If infusion reaction occurs, interrupt infusion, discontinue or decrease the rate, depending on the severity of the reaction and contact provider

☐ *600 mg, IV Piggyback, Injection, **Every 6 months starting ____/_____/_____***
Comments: 600 mg dose: Begin infusion at 40 mL/hour; increase by 40 mL/hour every 30 minutes to a maximum rate of 200 mL/hour. Infusion duration is 3.5 hours or longer. Monitor for infusion reactions during infusion and observe for at least one hour after infusion is complete. If infusion reaction occurs, interrupt infusion, discontinue or decrease the rate, depending on the severity of the reaction and contact provider

☑ Communication Order
Administer though a dedicated IV line using a 0.2 or 0.22 micron in-line filter

☑ Communication Order
Constant order, If patient develops fever, chills, rigors, hypotension or respiratory difficulty during infusion, STOP infusion and call MD/LIP.

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 60 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician.

☑ Communication Order (Month 1 to 12)
Ensure results of Hepatitis B surface antigen testing and record results if not present in medical record. Results must be within last 12 months.

☑ Communication Order (Month 1 to 12)
Ensure negative PPD or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Ocrevus (ocrelizumab) Treatment Plan

Temperature > 100 or HR <50 or > 130

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of PPD test or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of Hepatitis B surface antigen or if results are not available. Results must be within the last 12 months.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ Quantiferon(R)-TB Gold, 4T, Incu-(36971) (If Needed)
☑ Hepatitis B Surface Antibody, Qual-(499) (If Needed)
☑ Hepatitis B Surface Antigen w Ref/Conf-(498) (If Needed)
☑ Hepatitis B Core Antibody, Total-(501) (If Needed)
☑ CBC w/ Diff (If Needed)
☑ Sedimentation Rate (If Needed)
☑ C-Reactive Protein (If Needed)
☑ BUN (If Needed)
☑ ALT(If Needed))
☑ AST (If Needed)
☑ BMP (If Needed)
☑ Urinalysis with Microscopic, if indicated (If Needed)

Patient Monitoring Acknowledgement:

***** CMC Outpatient Infusion Services (OIS) shall ensure TB testing and Hepatitis B testing is completed prior to therapy initiation. If positive, OIS team will notify referring provider. Referring provider to manage subsequent care coordination for patients who screen TB positive, HBsAg+, or HBcAB+, or have increasing viral load.

Provider Initials_____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____