ARJ Infusion SERVICES
Specialty Pharmacy & Nursing Services

FAX completed form to ARJ (877) 451-8955
Intake Specialist (866) 451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Ocrevus Patient Referral Form

Patient Name: ______________________ **Date:** ______________

SSN#: ______________ DOB: ________ Primary Phone: ______________ Work Phone: ______________

Address: ______________________ City: ______________ State: ________ Zip: ________

Primary Diagnosis: *Please fill in appropriate ICD-10 code*

☐ **G35 Multiple Sclerosis** ______________________

☐ **Other ICD-10** ______________________

1 Patient Information: *In order to service your patient and facilitate insurance authorization, please complete the following.*

☐ NKDA Allergies: ______________________

Ht: ________ in/cm Wt: ________ lbs/kg Male ☐ Female ☐

Is this the first Ocrevus infusion: Yes ☐ No ☐

Date of last infusion: ______________ Next dose due: ______________

Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other: ____________ Lumen #: _____

Attach documents to FAX *(see below)*

☒ Copy of insurance card
☒ Patient demographics
☒ Labs
☒ H&P
☒ Immunization results, include HBV and TB

Other: ______________________

2 Clinical Information: *ARJ policies and protocols to be provided upon request.*

Initial Dosing	Maintenance Dosing	Directions	Quantity/Refills
Ocrevus: ☒ 300 mg/250 mL NS IV day 1 and day 15 ☐ Initial dose completed. Dispense maintenance dose only.	☒ 600 mg/ 500 mL NS IV every 24 weeks.	☒ Infuse per manufacturer guidelines	Dispense: 1 month supply on all selected medications Refill x12 months unless otherwise noted ☐ *Other:* ____________

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure

☒ **Give standard premedication 30 mins prior to infusion**
- **Antihistamine:** Diphenydramine 25-50 mg po
- **Steroid:** Methylprednisolone 100mg slow IV push over 5 mins
- **Pain/Fever:** Acetaminophen 325-650mg po

Alternative premedications *(if checked, item will replace the indicated standard premedication)*

Antihistamine:
- ☐ Diphenhydramine 50mg IV diluted in D5W or NS 50-100ml, infused over 10-15 mins.
- ☐ Fexofenadine 180mg po
- ☐ Cetirizine 10mg po

Steroid:
- ☐ Methylprednisolone __________ mg slow IV push over 5 mins.

Pain/Fever:
- ☐ Acetaminophen __________ mg po

☒ RN to monitor vital signs at start of infusion, every 30 minutes and 1 hour post infusion. RN to educate patient on possible side effects, allergic reactions, and when to contact physician.

☒ RN to instruct patient to hydrate pre/post infusion. RN to instruct patient to take Diphenhydramine 25-50 mg po and Acetaminophen 325-650 mg po every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache.

☐ Other: ______________________

Adverse Reaction Orders: *(Dispense 1 dose of each medication below)*

For mild reactions such as: itching, flushing, rash – reduce the infusion rate to half the rate at the onset of reaction and maintain reduced rate for at least 30min. If symptoms resolve rate can be increased per manufacturer guidelines. Administer appropriate medication based on symptoms occurring.

For severe reactions such as: bronchospasm, dyspnea – stop infusion and administer appropriate medication based on symptoms occurring. Restart the infusion only after all symptoms have resolved. When restarting, begin at half of the infusion rate at the time of onset of reaction. If this rate is tolerated increase the rate per manufacturer guidelines.

☒ If infusion stopped infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration.

☒ **Diphenhydramine**
50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 minutes or 50 mg/10 mL NS IV push over 2-3 minutes, as tolerated.

☒ **Methylprednisolone**
125 mg (**OR** ______________ mg) slow IV push over 5 minutes.

☒ **Acetaminophen**
325-650 mg (**OR** ______________ mg) po at onset of symptoms.

☒ **Ondansetron**: 4 mg slow IV push over 5 minutes or 4 mg ODT.

☒ **Epinephrine:** (1:1000) by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used.

3 Prescriber Information: *By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.*

Physician Name: ______________________ Office Contact: ______________________

Address: ______________________ City: ______________________

State: ____________ Zip: ________ Phone: ______________ Fax: ______________

License #: ______________ DEA#: ______________ NPI #: ______________

______________________ Date: ________
Physician Signature Required - Substitution Permitted

______________________ Date: ________
Physician Signature Required - Dispense as Written

Confidential Health Information: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization and under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Important Warning: This message is intended for the use of the person or entity to who it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any discrimination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.