Indiana University Health

Ocrevus Home Health Infusion Referral

To: IU Health Home Care *infusionhomecare@iuhealth.org* **Fax (317) 962-4737 * Phone (317) 963-4919**	***For NON-IU HEALTH physician referrals, please attach patient demographics, insurance, and clinic notes.***
From: **Phone:** **Fax** :	**Today's Date:** **ICD-10/Diagnosis:**
Patient Name: **DOB:** **MRN:**	**Patient Weight: _____kg or_____pounds** **Patient Height: _____cm or_____inches**

☒ **Home Infusion Therapy and Skilled Nursing Visits** for *Administration/Assessment / Education*	
Ocrevus specific order set	☐ Ocrevus initial 300mg IV on day 1 and 300mg IV on day 15 Ocrevus ☐ maintenance 600mg IV every 6 months ☐ Ocrevus Pre-medications, Administer 30 minutes prior to infusion: ☐ Methylprednisolone 100mg ☐ IV Diphenhydramine 50mg ☐ IV Acetaminophen 650mg PO Other pre-medications or alternate dosages_____
Has patient had this drug before?	☐ Yes, date last given_____Next dose due on_____ ☐ No
Hypersensitivity Reaction/Treatment	☒ IUHHC Anaphylaxis Adverse Drug Reaction Protocol if required per Home Care Approved Medication policy. Pharmacy to dispense epinephrine, diphenhydramine, and Normal Saline per IUHHC protocol
IV Access	☐ PIV - RN to place peripheral line at home and discontinue once IV therapy completed ☐ Port – supplies and flushes per IUHHC catheter maintenance protocol
Labs	☐ Labs and frequency_____

Physician Name (printed) _____

Physician Signature_____Date _____