



# Indiana University Health

## Ocrevus Home Health Infusion Referral

To: IU Health Home Care <a href="mailto:infusionhomecare@iuhealth.org">infusionhomecare@iuhealth.org</a> Fax (317) 962-4737 * Phone (317) 963-4919		***For NON-IU HEALTH physician referrals, please attach patient demographics, insurance, and clinic notes.***
From:		Today's Date:
Phone:	Fax :	ICD-10/Diagnosis:
Patient Name:	Patient Weight: _____ kg or _____ pounds	
DOB:	MRN:	Patient Height: _____ cm or _____ inches

<input type="checkbox"/> Home Infusion Therapy and Skilled Nursing Visits for Administration/Assessment / Education	
Ocrevus specific order set	<input type="checkbox"/> Ocrevus initial 300mg IV on day 1 and 300mg IV on day 15 Ocrevus <input type="checkbox"/> maintenance 600mg IV every 6 months <input type="checkbox"/> Ocrevus Pre-medications, Administer 30 minutes prior to infusion: <input type="checkbox"/> Methylprednisolone 100mg <input type="checkbox"/> IV Diphenhydramine 50mg <input type="checkbox"/> IV Acetaminophen 650mg PO Other pre-medications or alternate dosages _____
Has patient had this drug before?	<input type="checkbox"/> Yes, date last given _____ Next dose due on _____ <input type="checkbox"/> No
Hypersensitivity Reaction/Treatment	<input checked="" type="checkbox"/> 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	<input type="checkbox"/> PIV - RN to place peripheral line at home and discontinue once IV therapy completed <input type="checkbox"/> Port – supplies and flushes per IUHHC catheter maintenance protocol
Labs	<input type="checkbox"/> Labs and frequency _____

Physician Name (printed) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

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