BioPlus Infusion | Santa Barbara Pharmacy

Skip this form & e-prescribe! Select BioPlus from your EHR!

NEUROLOGY & MULTIPLE SCLEROSIS INFUSION

Fax: 866-523-5406
Phone: 800-829-3975
bioplusinfusion.com

Ship To: ☐ In Office ☐ Infusion Suite ☐ At Home ☐ Other_____

PATIENT INFORMATION

Name:	SSN:		DOB:
Address:	City:	State:	ZIP:
Home Phone:	Cell:	Gender: ○ Female ○ Male	
Email:	Allergies:		

CLINICAL INFORMATION

Primary Diagnosis (ICD-10):		
Description:	Weight:	Height:

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

OCREVUS® *(ocrelizumab)* 300 mg/10 mL (30 mg/mL)
Inital dosages must be completed under physican observation and cannot be administerd at home.
Date of Initial Dose 1: _____ **Date of Initial Dose 2:** _____
Subsequent Doses:
☐ 600 mg in 0.9% Sodium Chloride 500 mL IV once every 6 months infused over approximately 3.5 hours or longer. Date Needed: _____
☐ 600 mg in 0.9% Sodium Chloride 500 mL IV once every 6 months infused over approximately 2 hours or longer, as tolerated.
(for patients with no prior serious infusion reactions with any previous Ocrevus infusion) Date Needed: _____

Vyvgart® *(efgartigimod alfa-fcab)* 400 mg/20 mL (20 mg/mL)
☐ Infuse IV 10 mg/kg (Dose = _____ mg) weekly for 4 weeks (1 cycle). Infuse over 1 hour.
☐ Infuse _____ mg/kg (Dose = _____ mg) weekly for ____ weeks (1 cycle). Infuse over _____ hour(s).
In patients weighing 120 kg or more, the recommended dose is 1,200 mg per infusion.
According to the Package Insert: Administer subsequent treatment cycles based on clinical evaluation. The safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established.
Initiation of Last Cycle Date: _____ Quantity Sufficient of vials (1 cycle) Number of refills (Treatment cycles) authorized: _____

Pre-Medication 1x/year administered 30 minutes prior to infusion.
☐ Diphenhydramine: 25 mg capsule, 1-2 capsules PO, 15-30 minutes before each infusion.
☐ Methylprednisolone: 100 mg (or an equivalent corticosteroid) administered intravenously.
☐ Acetaminophen: 650 mg tablet, 1-2 tablets PO, 15-30 minutes before each infusion.
☐ Other_____ Strength: _____ Directions: _____

Vascular Access Device:
☐ Peripheral Catheter ☐ PICC ☐ Port ☐ Other (describe # of lumens): _____
Flush Orders: (If IV ordered, the following flush protocols will be followed)
☐ Sodium Chloride 0.9%
Peripheral Line: 3 mL before each dose and 3 mL after each dose and PRN
Central Line: 5-10 mL before each dose and 5-10 mL after each dose and PRN
☐ **Heparin 10 u/mL** Peripheral Line: 3 mL after last sodium flush and PRN
☐ **Heparin 100 u/mL** Central Line: 5 mL after last sodium flush and PRN
Provide needles, syringes, VAD supplies, and other ancillary supplies needed for infusion

Hydration Orders
Infuse ___ mg _____ solution ☐ Prior to ☐ Following

Anaphylaxis Kit Order **(Infusion Reaction Management x 1/year)**
☐ Epinephrine ☐ IM ☐ SUBQ Qty: ☐ Refills: ☐
Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) PRN severe allergic reaction, call 911. May repeat in 5-15 minutes, as needed.

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

NURSING

☐ **Nursing Agency:** _____ **Phone:** _____
Skilled Nursing Visits for Intravenous administration and education. To provide education related to the disease process and IG therapy.
To provide an assessment of patient's general overall health status. To provide skilled nursing visits PRN for additional education and support.

PHYSICIAN INFORMATION

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