

Ocrevus Zunovo

(ocrelizumab and hyaluronidase-ocsq)



PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies See List NKDA City, State, Zip: _____

Weight: _____ kg lbs Height: _____ in cm Email: _____

PRIMARY DIAGNOSIS

G35.A (RRMS) G35.B0 (PPMS-NOS) G35.B1 (Active PPMS) G35-B2 (Non-active PPMS)
G35.C0 (SPMS-NOS) G35.C1 (Active SPMS) G35.C2 (Non-Active SPMS) G35.D (MS-NOS)

PRESCRIPTION

Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)

Ocrevus Zunovo 920mg/23,000units via subcutaneous infusion every 6 months

Other: _____

Has patient received any doses of this medication in the past? Yes No

Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- Patient Demographics
- Most recent labs
- Negative Hep B
- H&P
- Medication List
- MRI Results

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol
(See aiscaregroup.com for detailed policy)

Other: Please fax other reaction orders if checking this box _____

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: acetaminophen 325mg, dexamethasone 20mg (or equivalent corticosteroid) PO and cetirizine 10mg PO 30 minutes before injection

Provider Prescribed: _____

LAB ORDERS—PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.