Local Infusion

MYLOCALINFUSION.COM

OCREVUS ZUNOVO (OCRELIZUMAB AND HYALURONIDASE-OCSQ) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

❑ MS, ICD 10: G35

❑ Relapsing Forms of MS (RMS) ❑ Primary Progressive MS (PPMS)

❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO ❑ Famotidine 20 mg IV ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO ❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Ocrevus Zunovo	❑ 23ml (920 mg ocrelizumab and 23,000 units hyaluronidase) every 6 months	❑ SubQ in Abdomen

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ MD: 240.224.8607 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371 ❒ NJ: 201.581.4521 ❒ VA: 703.202.0499

Order valid for 1 year from date of signature unless otherwise specified here: _____