Local Infusion

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# OCREVUS ZUNOVO (OCRELIZUMAB AND HYALURONIDASE-OCSQ) ORDER FORM

## PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

## DIAGNOSIS (Provider must specify)

❑ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
❑ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
❑ Primary progressive multiple sclerosis (PPMS), ICD 10: G35.B1 Active
❑ Non-active Primary progressive multiple sclerosis (PPMS), ICD 10: G35.B2
❑ Clinically isolated syndrome (CIS), ICD 10: G36.9

## 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

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ Dexamethasone 20mg PO
☑ Loratadine 10mg PO
❑ Desloratadine 5mg PO
❑ Benadryl 25mg PO
☑ Acetaminophen (Tylenol) 500 mg PO
❑ Cetirizine (Zyrtec) 10mg PO

❑ Other: _____ Dose: _____ Route: _____

We will NOT administer IV premedications for this medication.

## MEDICATION

| MEDICATION | DOSE / FREQUENCY | ROUTE |
|---|---|---|
| Ocrevus Zunovo | 920mg/23ml 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

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

**FAX NUMBERS:**
❑ CT: 203.433.0621
❑ FL: 904.877.9270
❑ MA: 413.296.8482
❑ MD: 240.224.8607
❑ ME: 207.407.7272
❑ NC: 919.984.8698
❑ NH: 603.217.5371
❑ NJ: 201.581.4521
❑ NY: 631.250.6020
❑ OH: 937.871.4594
❑ PA: 610.273.5998
❑ SC: 864.973.6279
❑ VA: 703.202.0499