



# OCREVUS & OCREVUS ZUNOVO

(ocrelizumab) & (ocrelizumab and hyaluronidase-ocsq)

## PATIENT INFORMATION

PATIENT NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
ALLERGIES:  SEE LIST  NKDA WEIGHT:  LB OR  KG

## REQUIRED DOCUMENTATION

- |                   |                       |                          |                    |                     |
|-------------------|-----------------------|--------------------------|--------------------|---------------------|
| 1. Insurance Card | 2. History & Physical | 3. Patient Demographics  | 4. Medication List | 5. Most Recent Labs |
| 6. MRI Results    | 7. Negative Hep B     | 8. Immunoglobulins Panel |                    |                     |

## PRIMARY DIAGNOSIS

- |   |   |
|---|---|
| <input type="checkbox"/> G35.A Relapsing-remitting multiple sclerosis                 | <input type="checkbox"/> G35.C1 Active secondary progressive multiple sclerosis     |
| <input type="checkbox"/> G35.B0 Primary progressive multiple sclerosis, unspecified   | <input type="checkbox"/> G35.C2 Non-active secondary progressive multiple sclerosis |
| <input type="checkbox"/> G35.B1 Active primary progressive multiple sclerosis         | <input type="checkbox"/> G35.D Multiple sclerosis, unspecified                      |
| <input type="checkbox"/> G35.B2 Non-active primary progressive multiple sclerosis     | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> G35.C0 Secondary Progressive multiple sclerosis, unspecified |   |

## LABS ORDERS: PLEASE INCLUDE FREQUENCY

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

## PRE-MEDICATIONS

Per infusion clinic protocol: **For Ocrevus:** Acetaminophen 650mg PO, Diphenhydramine 25mg IV, Methylprednisolone 100mg IV 30 minutes prior to start.

**For Ocrevus Zunovo:** Per manufacturer guidelines, premedicate with acetaminophen 325mg PO, loratadine 10mg (or equivalent antihistamine) PO, 20mg dexamethasone (or equivalent corticosteroid) PO. \_\_\_\_\_

Provider Prescribed: \_\_\_\_\_

## PRIMARY MEDICATION ORDER

- Ocrevus 300mg IV on Day 1 & Day 15, then 600mg IV every 6 months after initial dose  Ocrevus 600mg IV every 6 months  
 Ocrevus Zunovo 920mg/23,000units via SubQ every 6 months  
 Other \_\_\_\_\_ FIRST DOSE?:  Yes  No  Refill x12 months unless otherwise noted.

## LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC  Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See [lifespecialtysolutions.com](http://lifespecialtysolutions.com) for detailed policy)  
 Other Flush Orders: Please send other line care orders if checking this box

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See [lifespecialtysolutions.com](http://lifespecialtysolutions.com) for detailed policy)  
 Other: (Please send other reaction orders if checking this box)

## PRESCRIBER INFORMATION

PROVIDER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
OFFICE CONTACT: \_\_\_\_\_ FAX: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_ NPI AND LICENSE: \_\_\_\_\_

X

PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_