

Ocrevus Zunovo

(ocrelizumab and hyaluronidase)

Treatment Location: Dublin, OH Lancaster, OH

PROVIDERS: Please include the following to expedite the order:

Patient Demographics, Insurance Information, All Clinical Documentation Supporting the Diagnosis, Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing, Recent Labs Including Hep B Results, Serum Immunoglobulins, Liver Function Tests

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): G35.A G35.B1 G35.B2 G35.C1 ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- Center will use Hypersensitivity protocol established by Infuse One Ohio
- Hep B (HBsAb and anti-HBc) Test Results (list & attach clinicals): _____
- Serum Immunoglobulins (list results & attach clinicals) _____
- Liver Function (ALT, AST, Alkaline Phosphatase, Bilirubin) Test Results (list results and attach clinicals) _____

THERAPY ADMINISTRATION

- Ocrevus Zunovo SQ Injection
Dose: 920 mg/23,000 units hyaluronidase/23 mL administered subcutaneously in the abdomen over 10 minutes
Frequency: Every 6 months
- Monitor patients for 1 hour after the completion of initial injection and for 15 minutes after subsequent injections.
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

PRE-MEDICATION ORDERS

It is recommended to pre-medicate with oral Dexamethasone or an equivalent corticosteroid and an antihistamine (eg desloratadine) approximately 30 minutes prior to each injection.

- Dexamethasone 20mg PO
- Claritin 10mg PO
- Acetaminophen 325mg / 500mg / 650mg PO
- Other: _____
- Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

Provider Name (Print)	Provider Signature	Date
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- Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.