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: _____

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

## 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
❑ Benadryl 25mg PO
☑ Loratadine 10mg PO
☑ Acetaminophen (Tylenol) 500 mg PO
❑ Desloratadine 5mg 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 |

## LABS / SPECIAL INSTRUCTIONS