Ocrevus Zunovo

(ocrelizumab and hyaluronidase-ocsq)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Multiple sclerosis (G35)

Type: ☐ RRMS ☐ SPMS ☐ PPMS ☐ PRMS ☐ CIS

☐ Other: _____

PRESCRIPTION

Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)

☐ Ocrevus Zunovo 920mg/23,000units via subcutaneous infusion every 6 months

☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs
- MRI Results
- Negative Hep B

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☐ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol
(See aiscaregroup.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☑ Per infusion center protocol: acetaminophen 325mg, dexamethasone 20mg (or equivalent corticosteroid) PO and cetirizine 10mg PO 30 minutes before injection

☐ Provider Prescribed: _____

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.