

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Ocrevus Zunovo™ (ocrelizumab and hyaluronidase-ocsq) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG Gender: Allergies: See list NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

G35- Relapsing Remitting Multiple Sclerosis
G35- Primary Progressive Multiple Sclerosis
-Other:

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	Quantitative Serum Immunoglobulin screening	THERAPY:	
6	REQUIRED: HBsAg, anti-HBc, and anti-HBs		
			Continue current order until insurance approved

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive Ocrevus Zunovo™ if receiving antibiotics for active infectious process, antifungal therapy, fever and/or suspected infection, and/or recent or planned surgery.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

Premedication with dexamethasone 20mg (or equivalent corticosteroid) and an antihistamine administered at least 30 minutes prior to each Ocrevus Zunovo administration to reduce the risk of local and systemic injection reactions. Antipyretics may also be considered.

MEDICATION:

Ocrevus Zunovo™ 920mg/23,000 units in 23ml subcutaneously over approximately 10 minutes every 6 months.

DO NOT administer the remaining priming volume in the subcutaneous set to the patient.

PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Diphenhydramine	25mg	50mg		
	Fexofenadine	60mg	180mg		
	Certirizine	10mg			
	Loratidine	10mg			
	Dexamethasone	20mg			
	Other:				

SPECIAL/LAB ORDERS:

Monitor patient for at least 1 hour for the initial dose. For subsequent doses, monitor for 15 minutes.



Refills x 12 months, if frequency is defined, unless noted otherwise here:

NURSING ORDERS:

Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders which can be found on our website.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

DATE:

Dispense as written/Brand medically necessary	Substitution permitted