Referral Status:				MRN:
	New referral		Order change		Order Renewal
Patient preferred clinic:				

Rev 4.29.25

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: / PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

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

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 corticosteriod) 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.

Route	Medication								
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	

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- [ ] **Patient demographics - address, phone number, SS#, etc.**
- [ ] **Insurance information - copy of the card(s) if possible**
- [ ] **Plan of Treatment/Orders**
- [ ] **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- [ ] **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com