Fax: 832-895-4040
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adaptIV infusion

Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

☐ Hepatitis B status & date (list results here & attach clinicals):

_____

Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Ocrevus induction.

☐ I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals):

_____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV

☐ famotidine (Pepcid) 20mg PO

☐ methylprednisolone (Solu-Medrol) ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____

Dose: _____ Route: _____

Frequency: _____

THERAPY ADMINISTRATION

☐ **Ocrevus Zunovo** (ocrelizumab and hyaluronidase-ocsq) 920 mg/23,000 units (920 mg ocrelizumab and 23,000 units of hyaluronidase) administered as a single 23 mL subcutaneous injection in the abdomen over approximately 10 minutes every 6 months

☐ Patient required to stay for 60-min observation post infusion

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

_____ _____ _____

Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK