Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

OCREVUS ZUNOVO™
(ocrelizumab and hyaluronidase-ocsq)

Date: _____

PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M ☐ F ☐
☐NKDA Allergies:		Weight lbs/kg:	

PHYSICIAN INFORMATION

Physician Name:	Practice Name:	
Address:	Office Contact Name:	Office Contact #:
Phone: Fax:	Email (for updates):	

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

OCREVUS ZUNOVO is a CD20-directed cytolytic antibody indicated for the treatment of:

- Relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults (1)
- Primary progressive MS, in adults (1)

☐ **ICD-10*:** _____
☐ **Dx Code:** _____
☐ **Dx Code:** _____

PRE-MEDICATION

☐ Tylenol PO 650mg ☐1000mg ☐other _____
☐ Solumedrol 125mg IV ☐other _____
☐ Benadryl ☐IVor ☐PO ☐25mg ☐50mg ☐other _____
☐ Dexamethasone ☐20mg IV ☐20mg ☐PO ☐other _____
☐ Desloratadine ☐5mg ☐PO
☐ _____ *(other)* ☐ _____ *(other)*

DIAGNOSIS *Please provide ICD-10 code*

☐ G35-MS

WARNINGS AND PRECAUTIONS

hhttps://www.gene.com/download/pdf/ocrevus_zunovo_prescribing.pdf

OCREVUS ZUNOVO ORDERS

PATIENT WEIGHT

_____ lbs.
_____ kg

DOSAGE:

☐ Injection 920mg ocrelizumab and 23,000 units of hyaluronidase per 23ml (40 mg and 1,000 units/mL) solution in a single-dose vial

FREQQUENCY:

☐ Every 6 months for _____ month
☐ Other: _____

LAB DRAW REQUEST

☐ Labs: _____
☐ Freq:_____

NOTES/ADDITIONAL COMMENTS:

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Recent labs to **include Hepatitis Panel and CBC,** as well as CMP and quantitative, if available
*Please send any other recent labs
_____ Recent Progress note and MRI of Brain
_____ Other

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Diagnosis Code: _____
Order/dosage: _____
Signature: _____