Ocrevus Zunovo

(Ocrelizumab and hyaluronidase-ocsq)

Provider Order Form rev. 09/16/2025

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS ***(Please provide ICD-10 code in space provided)***

☐ G35.A Relapsing-Remitting MS ☐ G35.B0 Primary Progressive MS, Unspecified ☐ G35.B1 Active Primary Progressive MS

☐ G35.B2 Non-Active Primary Progressive MS ☐ G35.C0 Secondary Progressive MS, Unspecified ☐ G35.D MS, Unspecified

☐ G35.C1 Active Secondary Progressive MS ☐ G35.C2 Non-Active Secondary Progressive MS ☐ Other:

THERAPY ADMINISTRATION & DOSING

☑ Administer Ocrevous Zunovo 920mg/23,000u subcutaneously (abdomen only) over 10 minutes once every 6 months.
☑ Monitor patient for 60mins after initial injection, subsequent injections monitor for 15 minutes.

PRE-MEDICATION ORDERS-30 minutes prior to injection

☐ Tylenol ☐500mg ☐650mg PO
☑ Antihistamine-write in preferred med. (**required**)
Rx_____ mg_____PO
☑ Decadron 20mg PO (**required**)
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for abnormal vital signs or signs/symptoms of active infection or recent live vaccine.
☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications. MRI.
Required Labs: Hepatitis B, Serum Ig levels

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.