

Ocrelizumab and hyaluronidase-ocsq (OCREVUS ZUNOVO)

PROVIDERS: Please include the following information to expedite the order:
Patient demographics, insurance information, most recent visit notes, Hep B status, and applicable labs

PATIENT INFORMATION

Patient: _____ DOB: _____
ICD-10 (Required): _____ Description: _____
Allergies: _____ NKDA Weight: _____ lb kg
Patient Status: New to Therapy Continuation of Therapy Last Treatment Date: _____ Next Due Date: _____

REFERRAL STATUS New Referral Updated Order Order Renewal

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- Utilize hypersensitivity protocol established by Redeemer Health Infusion Therapy Center
- Provide nursing care and observation according to Redeemer Health Infusion Therapy Center policies and procedures
- Hepatitis B status and date (list results here and attach clinicals):

- Recent quantitative serum immunoglobulin test (list results here and attach clinicals):

THERAPY ADMINISTRATION

- Ocrelizumab and hyaluronidase-ocsq (OCREVUS ZUNOVO)
Dose: 920mg ocrelizumab and 23,000 units hyaluronidase
Frequency: every 6 months
Route: subcutaneous injection
Rate: inject over 10 minutes
Monitoring: Patient required to stay for 60-minute observation
after initial injection and then for at least 15 minutes
after subsequent injections
Refills: No Refills 12 months _____

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- Treatment naïve patient required labs:** ALT, AST, Alkaline Phosphate, Bilirubin (list results here and attach clinicals):

- Please check this box if you do NOT authorize Redeemer Health Infusion Therapy Center to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

- acetaminophen (TYLENOL) 500 mg 650 mg 1000 mg PO
- cetirizine (ZYRTEC) 10 mg PO
- loratadine (CLARITIN) 10 mg PO
- Dexamethasone 20mg PO
- Other _____

SPECIAL INSTRUCTIONS

Redeemer Health Infusion Therapy Center will conduct peer-to-peer review(s) on behalf of the prescribing provider for any insurance denials. If you DO NOT AUTHORIZE Redeemer Health Infusion Therapy Center to do this on your behalf, check this box.

Note to prescriber: It is recommended to premedicate with oral dexamethasone or equivalent corticosteroid and oral antihistamine 30 minutes prior to injection. Consider antipyretic.

Provider Name (Print): _____ **Provider Signature (No Stamps):** _____ **Date:** _____