

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: ☐ M ☐ F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)			
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
CLINICAL INFORMATION			
☐ G35.A Relapsing-remitting multiple sclerosis ☐ G35.B0 Primary progressive multiple sclerosis, unspecified ☐ G35.B1 Active primary progressive multiple sclerosis ☐ G35.B2 Non-active primary progressive multiple sclerosis ☐ G35.C0 Secondary progressive multiple sclerosis, unspecified ☐ G35.C1 Active secondary progressive multiple sclerosis ☐ G35.C2 Non-active secondary progressive multiple sclerosis ☐ G35.D Multiple sclerosis, unspecified ☐ Other (Specify ICD-10 Code): _____ Date of Last MRI: _____ Past DMT Therapies: _____ Hepatitis B (HBsAg and anti-HBV) Test Results: ☐ Positive ☐ Negative Quantitative Serum Immunoglobulins Test Results: _____ Date of last treatment with an OCREVUS product (if applicable) (MM/DD/YYYY): _____/_____/_____			
ORDERS			
Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
Medication	Dose/Frequency	Quantity/Refills	
☐ OCREVUS ZUNOVO™ (920mg/23mL)	☐ 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 ☐ Other: _____	☐ Quantity: 1 Vial	
Pre-Medication	Dose/Strength	Directions	
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed	
☐ Cetirizine	☐ 10mg	☐ Take 1 tablet PO prior to infusion or as directed	
☐ Dexamethasone	☐ 20mg	☐ Take 1 tablet PO prior to infusion or as directed	
☐ _____	_____	_____	
ANAPHYLACTIC REACTION (AR):			
☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary ☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary ☐ Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary			

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.



OCREVUS ZUNOVO™

Please Fax Completed Form To: **800-783-9146**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

- ☐ Methylprednisolone 40mg IVP
☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr
☐ Other: _____

SIGNATURE

X _____

Prescriber Signature

Date: _____

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.