OCREVUS ZUNOVO™

Please Fax Completed Form To: 800-783-9146

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

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

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

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

SIGNATURE

X_____ Date: _____

Prescriber Signature