Ocrelizumab and hyaluronidase-ocsq (Ocrevus Zunovo) Patient Referral Form

Patient Demographics Information

Patient Name	SSN#	DOB

Patient Address

Primary Phone	Cellular Phone	Work Phone

Emergency Contact Name, Relationship	Emergency Contact Phone Number

Additional Documentation Needed

- ❁ Copy of insurance cards
- ❁ Patient face sheet w/demographics
- ❁ History and Physical
- ❁ CBC w/diff, BMP, & CMP
- ❁ Recent vitals including blood pressure
- ❁ Screening for HBV infection

Patient Insurance Information

Insurance Plan #1		Insurance Plan #2	
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

Patient Clinical Information

Gender	Height (inches)	Weight (lbs.)	Allergies (food/drug)
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Statement of Medical Necessity / Primary Diagnosis

ICD10: Description of diagnosis:

Medication Information / Prescription and Orders

Medication:

Ocrevus Zunovo

Directions:

Infuse SubQ per manufacturer guidelines over approximately 10 minutes.

Quantity/Refills

Dispense: #1 dose

+ _____ refills

☐ Other

Dosing:

□ MS dosing: 920 mg/23,00 units SubQ every 6 months

Date of Last Dose:

Premedications

Give premedication(s) 30 minutes prior to infusion

Acetaminophen	□ 325-650 mg PO	**OR**	□ _____ mg PO
Dexamethasone	□ 20 mg PO		
Diphenhydramine	□ 25-50 mg PO		
Other	□ _____		

Quantity/Refills

Dispense: quantity #QS

PRN refills (unless otherwise noted)

☐ Other

Adverse Reaction Orders

- ❁ Mild reaction: Pause infusion and resume after symptoms have resolved
- ❁ Moderate reaction: Pause infusion and give diphenhydrAMINE 50mg PO. Resume infusion after symptoms have resolved. Notify Pharmacist.
- ❁ Severe reaction (w/breathing problems): stop infusion, call 911 and administer EPHINEPHrine 0.3 mg or 0.15 mg IM (as determined by patient weight).

Prescriber Information

Physician Name	Office Contact

Practice Address

NPI#	License #	Practice Phone

Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date