

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

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

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 | - History and Physical | - Recent vitals including blood pressure |
| - Patient face sheet w/demographics | - CBC w/diff, BMP, & CMP | - 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 ☐ M ☐ F	Height (inches)	Weight (lbs.)	Allergies (food/drug)
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Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:
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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

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