



# OCREVUS ZUNOVO™

Please Fax Completed Form To: 888-340-3699

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

Please Send a Copy of The Patient's up-to-Date Clinical Notes

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION			
<input type="checkbox"/> G35.A Relapsing-remitting multiple sclerosis	<input type="checkbox"/> G35.B0 Primary progressive multiple sclerosis, unspecified	<input type="checkbox"/> G35.B1 Active primary progressive multiple sclerosis	<input type="checkbox"/> G35.B2 Non-active primary progressive multiple sclerosis
<input type="checkbox"/> G35.C0 Secondary progressive multiple sclerosis, unspecified	<input type="checkbox"/> G35.C1 Active secondary progressive multiple sclerosis	<input type="checkbox"/> G35.CD Non-active secondary progressive multiple sclerosis	<input type="checkbox"/> G35.D Multiple sclerosis, unspecified
<input type="checkbox"/> Other (Specify ICD-10 Code): _____			
Date of Last MRI: _____		Past DMT Therapies: _____	
Hepatitis B (HBsAg and anti-HBV) Test Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		Quantitative Serum Immunoglobulins Test Results: _____	
Date of last treatment with an OCREVUS product (if applicable) (MM/DD/YYYY): _____/_____/_____			

ORDERS		
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____		
Medication	Dose/Frequency	Quantity/Refills
<input type="checkbox"/> OCREVUS ZUNOVO™ (920mg/23mL)	<input type="checkbox"/> 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 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Quantity: 1 Vial Refills: _____
Pre-Medication	Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Cetirizine	_____	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed
<input type="checkbox"/> Dexamethasone	_____	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed
<input type="checkbox"/> _____	_____	_____

INFUSION REACTION ORDERS
<p><b>Mild reaction protocol:</b></p> <p><input checked="" type="checkbox"/> Diphenhydramine 25mg IV, one time, for pruritus.</p> <p><i>If symptoms worsen, see orders for moderate to severe reactions.</i></p> <p><b>Moderate reaction protocol:</b></p>

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Acetaminophen 650mg PO, one time, for pyrexia or rigors  
 Diphenhydramine 50mg IV, one time, for pruritus or urticaria  
 Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms  
*If symptoms worsen, see interventions for severe reactions*  
**Severe reaction protocol: (Call 911 if initiated):**  
 Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)  
 Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis  
 Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis  
 Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms  
 Epinephrine 0.3mg/0.3mL IM into mid-antrolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

## FLUSHING & LOCKING ORDERS

### Flushing Protocol (>66lbs/33kg)

<b>PIV and Midline:</b> <input checked="" type="checkbox"/> 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	<b>Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:</b> <input checked="" type="checkbox"/> 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw
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### Locking Protocol (>66lbs/33kg)

<b>PIV and Midline:</b> <input checked="" type="checkbox"/> Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	<b>PICC:</b> <input checked="" type="checkbox"/> Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	<b>Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:</b> <input checked="" type="checkbox"/> Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush
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**\*\* May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

## SIGNATURE

We hereby authorize Infuse IQ LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_

Date: \_\_\_\_\_

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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