Ocrevus Zunovo™ Infusion Form

Fax Referral To: 877-438-9380

ContinuumRx Specialty Infusion Services™

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____MS - Relapsing Remitting
_____MS - Primary Progressive
_____Other: _____

Infusion Center – Lab Orders (Check order for Infusion Center to manage):

☐ Obtain Quantitative Immunoglobin

Please attach the following: 1. List of current Medications 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results (surface antigen and Core AB)

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **Ocrevus Zunovo™ (ocrelizumab and hyaluronidase-ocsq)**

New Start:

☐ **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**

Pre-Medication Orders:

☐ Acetaminophen (Tylenol) ☐ 500 mg ☐ 650 mg ☐ 1000 mg PO
☐ Cetirizine (Zyrtec) 10mg PO
☐ Loratadine (Claritin) 10mg PO
☐ Diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Dexamethasone 20mg PO
☐ Other: _____ Dose: _____ Route: _____

(It is recommended to add an oral corticosteroid and an antihistamine, with or without an antipyretic)

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date