Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Ocrevus/Ocrevus Zunovo Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:
Multiple Sclerosis ICD-10: G35
Type: ❑ Relapsing-Remitting ❑ Primary-Progressive ❑ Secondary-Progressive ❑ Clinically Isolated
Other:_____ ICD-10:_____

ORDER FOR <u>OCREVUS</u> (<u>OCRELIZUMAB</u>):

- ☐ **300 mg** IV at 0 and 2 weeks, then 600 mg IV infused every 6 months X 1 year
- ☐ **600 mg** IV infused every 6 months X 1 year

****Patient to be observed for at least 1 hour after each infusion****

ORDER FOR <u>OCREVUS ZUNOVO</u> (<u>OCRELIZUMAB HYALURONIDASE</u>):

- ☐ 920mg dose Ocrelizumab and 23,000 units/dose hyaluronidase **subcutaneously** in the abdomen infused over 10 minutes every 6 months x 1 year

****Patient to be observed for at least 1 hour after first injection and at least 15 minutes after subsequent injections****

PRE-MEDICATIONS:

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, SubQ, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion
LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:
Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

- ☐ **Expanded Disability Status Scale (EDSS) score: _____**

☐ Include labs, imaging and/or test results to support diagnosis

- ☐ **MRI**

☐**If applicable** - Last known biological therapy: _____ and last date received: _____.
If the patient is switching to biologic therapies, please perform a wash out period of _____ weeks prior to starting Ocrevus.

Additional REQUIRED Information:

☐ Hepatitis B screening test completed within 12 months - this includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - please include results

- ☐ Positive OR ☐ Negative
- ☐ Serum Immunoglobulin Panel (required)
- *If Hepatitis B results are positive - please provide documentation of treatment or medical clearance

☐ Other medical necessity: _____

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