Nevada Infusion
Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511
Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706
PH: 775-453-0667 | Fax: 775-470-8478

Ocrevus Zunovo Order Form

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

DIAGNOSIS:

- ❑ Relapsing-Remitting MS ICD-10: G35A
- ❑ Primary-Progressive MS NOS ICD-10: G35B0
- ❑ Active Primary Progrssive MS ICD-10: G35B1
- ❑ Active Secondary Progressive MS ICD-10: G35C1
- ❑ Non-Active Primary Progressive MS ICD-10: G35B2
- ❑ Non-Active Secondary Progressive MS ICD-10: G35C2
- ❑ Secondary-Progressive MS NOS ICD-10: G35C0
- ❑ Multiple Sclerosis, NOS ICD-10:G35D
- ❑ Other_____

ICD-10:_____

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

- ☑ **920 mg 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 FOR OCREVUS ZUNOVO:

- ☑ Acetaminophen 650mg PO 30 minutes prior to injection
- ☑ Dexamethasone (or equivalent) 20 mg PO 30 minutes prior to injection
- ☑ Zyrtec (Cetirizine) 10 mg PO 30-60 minute prior to injection
- ☑ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

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

ACCESS: SubQ
FLUSHING: N/A
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 documentation to include past tried and/or failed therapies

☐ Supporting clinical notes and H&P (to support primary diagnosis) 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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Revised: 12/2025