# Ocrevus Zunovo

## (Ocrelizumab and hyaluronidase-ocsq)

**Provider Order Form rev.** 07/30/2025

### PATIENT INFORMATION

**Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

### DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Multiple Sclerosis:

Other: Description:

### THERAPY ADMINISTRATION & DOSING

☐ Administer Ocrevous Zunovo 920mg/23,000u subcutaneously (abdomen only) over 10 minutes once every 6 months.
☑ Monitor patient for 60mins after initial injection, subsequent injections monitor for 15 minutes.

### PRE-MEDICATION ORDERS-30 minutes prior to injection

☐ Tylenol ☐ 500mg ☐ 650mg PO
☑ Antihistamine-write in preferred med. (**required**)
Rx: _____ mg: _____ PO
☑ Decadron 20mg PO (**required**)
☐ Other: _____

### LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: _____
☐ CMP ☐ at each dose ☐ every: _____

☐ Other: _____

### NURSING

☑ Hold infusion and notify provider for abnormal vital signs or signs/symptoms of active infection or recent live vaccine.
☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

### ADDITIONAL ORDERS

### PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

### REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications. MRI.
**Required Labs:** Hepatitis B, Serum Ig levels

**Provider Name *(print)*** **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

**Disclaimer:** By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.