

Ocrevus Zunovo

(Ocrelizumab and hyaluronidase-ocsq)

Provider Order Form rev. 09/18/2025



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)

☐ G35.A Relapsing-Remitting MS ☐ G35.B0 Primary Progressive MS, Unspecified ☐ G35.B1 Active Primary Progressive MS
☐ G35.B2 Non-Active Primary Progressive MS ☐ G35.C0 Secondary Progressive MS, Unspecified ☐ G35.D MS, Unspecified
☐ G35.C1 Active Secondary Progressive MS ☐ G35.C2 Non-Active Secondary Progressive MS Other: _____

THERAPY ADMINISTRATION & DOSING

☐ Administer Ocrevus 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.