Ocrevus Zunovo



Ph: 518-782-3899 | Fax: 518-782-3884

Please include the forest	ollowing to	Progress Not Previous Me	te Releva dications	nt to the Dia , Viral Hepa	ation, Current CBC & CMP, Last agnosis, Current Medications, titis Results, TB Results, ulin, Written Informed Consent	
PATIENT INFORM	IATION		PRE	SCRIBER I	NFORMATION	
Patient Name:			Prescriber's Name:			
Patient Contact Number:			NPI:		Date:	
DOB:			Phor	ie:	Fax:	
Allergies:			Offic	Office Address:		
Weight:Olbs Okg Height:			Cont	Contact Person:		
Diagnosis:			Con	Contact Email:		
ICD 10:						
prescribing provider fo	-			-	e a Peer-to-Peer on behalf of the or treatment.	
PREMEDS						
○ No Premeds						
Benadryl:	○PO ○IV	0	25 mg	○ 50 mg		
Acetaminophen:	ОРО	0	650 mg	○ Other:		
Methylprednisolone:	\circ IV	0		_mg		
Other:						
○ You authorize Infusio	onCare to utiliz	e the hypersens	sitivity pro	otocol establ	ished by InfusionCare.	
Signature:					Date:	

Date of Last Treatment, if Continuation:	
Route subcutaneous	
Dose: 920 mg/23,000 units hyaluronidase/23 mL adm minutes	inistered subcutaneously in the abdomen over 10
Frequency: Every 6 months	
(if not indicated order will expire 6 months from date si	igned)
O Monitor patients for 1 hour after the completion of in injections.	nitial injection and for 15 minutes after subsequent
To ensure that a Brand name product be dis "Brand Medically Necessary" on prescripti authorized to administer generic or biosim.	ion form. If not indicated, InfusionCare is
LAB ORDERS	
○ No Labs	
List:	Frequency:
	rroquonoy.
Signature:	Date:

Date: _____

OCREVUS ZUNOVO DOSAGE