

# Ocrevus Zunovo



Ph: : 518-836-3030 | Fax: 518-836-3020

Date: \_\_\_\_\_

**Please include the following to expedite the order**

**Demographics, Insurance Information, Current CBC & CMP, Last Progress Note Relevant to the Diagnosis, Current Medications, Viral Hepatitis Results, TB Results, Quantitative Serum Immunoglobulin**

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Patient Contact Number: \_\_\_\_\_

DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD 10: \_\_\_\_\_

Please check this box if you **DO NOT** authorize UHO to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

## PREMEDS

No Premeds

Benadryl:  PO  IV  25 mg  50 mg

Acetaminophen:  PO  650 mg  Other: \_\_\_\_\_

Methylprednisolone:  IV  \_\_\_\_\_ mg

Other: \_\_\_\_\_

You authorize UHO to utilize the hypersensitivity protocol established by InfusionCare.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## OCREVUS ZUNOVO DOSAGE

Date of Last Treatment, if Continuation: \_\_\_\_\_

Route subcutaneous

**Dose:** 920 mg/23,000 units hyaluronidase/23 mL administered subcutaneously in the abdomen over 10 minutes

**Frequency:** Every 6 months

(if not indicated order will expire 6 months from date signed)

Monitor patients for 1 hour after the completion of initial injection and for 15 minutes after subsequent injections.

***To ensure that a Brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, UHO is authorized to administer generic or biosimilar.***

## LAB ORDERS

No Labs

List: \_\_\_\_\_

Frequency: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_