INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Ocrevus Zunovo *ocrelizumab and hyaluronidase-ocsq*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
☐ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
☐ Active primary progressive multiple sclerosis (PPMS), ICD 10: G35.B1
☐ Non-active Primary progressive multiple sclerosis (PPMS), ICD 10: G35.B2
☐ Clinically isolated syndrome (CIS), ICD 10: G36.9

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
☐ Labs and tests supporting diagnosis
☐ Baseline liver function tests (LFTs) (ALT, AST, bilirubin, alkaline phosphatase) within 6 months
☐ Demographics
☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Dexamethasone 20 mg PO
☐ Diphenhydramine (Benadryl) 25 mg PO
☑ Loratadine 10 mg PO
☑ Acetaminophen (Tylenol) 500 mg PO
☐ Desloratadine 5 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

We will NOT administer IV premedications for this medication.

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Ocrevus Zunovo	920mg/23ml ocrelizumab and 23,000 units hyaluronidase every 6 months	SubQ in Abdomen

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____