



OCREVUS ZUNOVO (ocrelizumab and hyaluronidase-ocsq) ORDER FORM

PATIENT NAME: _____ DOB: _____ WT: _____ HT: _____

ALLERGIES: _____

DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: OCREVUS ZUNOVO (ocrelizumab and hyaluronidase-ocsq) NO YES

Please note: OCREVUS ZUNOVO (ocrelizumab/hyaluronidase SQ) is not interchangeable with OCREVUS (ocrelizumab IV)

BRAND: _____ LAST DOSE DATE: _____

DIAGNOSIS: _____ ICD 10 CODE(S): _____

MEDICATION ORDERS

DOSE/FREQUENCY:

920 mg ocrelizumab/23,000 units hyaluronidase SQ over 10 minutes every 6 months (use in abdomen only)

Other: _____

PREMEDICATION: 30 minutes prior to injection

Acetaminophen 1000 mg PO

Dexamethasone 20 mg PO

Cetirizine 10 mg PO

Acetaminophen 500 mg PO

Other (include dose and route): _____

Orders are valid for 1 year. For a shorter duration, indicate here: _____

STANDARD IV ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- Monitor vital signs (temp, HR, RR, BP) before therapy and every 15-30 minutes.
- If an infusion reaction occurs, monitor vital signs until symptoms subside. If the reaction persists or worsens, initiate reaction protocol and notify physician.
- Observe patient for 1 hour after completion of first dose, then for at least 15 minutes after subsequent doses.

LABS

LAB ORDERS:

CBC w/ diff CMP CRP

Serum immunoglobulins Other: _____

LAB FREQUENCY:

Every dose

Other: _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- Hepatitis B serology labs
- Serum Immunoglobulin labs
- Documentation if patient has an active infection

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Baseline labs (CBC w/ diff, CMP, CRP)
- Review that all age-appropriate vaccinations are up-to-date as per current immunization guidelines

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

PRESCRIBER SIGNATURE (substitution)

PRESCRIBER SIGNATURE (dispense as written)

PRINT NAME (FIRST AND LAST)

DATE