Ocrelizumab and hyaluronidase-ocsq (Ocrevus Zunovo)

IVX HEALTH

Provider Order Form *rev. 11/12/24*

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 05.01.2023)

☐ Hepatitis B status & date (list results here & attach clinicals):
_____

Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Ocrevus induction.

☐ I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals):
_____

☐ I instruct IVX Health to draw quantitative serum immunoglobulin prior to first induction infusion (if required by payor).

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO
☐ famotidine (Pepcid) 20mg PO
☐ dexamethasone (Decadron) 20mg PO
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

THERAPY ADMINISTRATION

☑ **Ocrelizumab and hyaluronidase-ocsq (**Ocrevus Zunovo) subcutaneous infusion

☐ Induction:
- Dose: 920mg ocrelizumab and 23,000 units hyaluronidase
- Frequency: every 6 months
- Duration: inject over 10 minutes
- Monitor patients for at least one hour after the initial injection, and for at least 15 minutes after subsequent injections

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

*Hepatitis B virus and quantitative serum immunoglobulin screening are required before the first dose. *For Ocrevus Zunovo pre-medicate with dexamethasone (or an equivalent corticosteroid and an antihistamine (e.g. desloratadine) at least 30 minutes prior to each injection. *Monitor patients closely during all injections, for at least one hour after the initial injection, and for at least 15 minutes after subsequent injections.

Provider Name (Print) **Provider Signature** **Date**

FAX NUMBERS

☐ AUSTIN: 512-772-2824	☐ CONNECTICUT: 860-955-1532	☐ INDIANAPOLIS: 844-983-2028	☐ NORTH CENTRAL FL: 352-756-4191	☐ RALEIGH: 919-287-2551
☐ BAY AREA: 844-889-0275	☐ DAYTONA: 386-259-6096	☐ JACKSONVILLE: 904-212-2338	☐ NORTH JERSEY: 551-227-2823	☐ SAN ANTONIO: 726-238-9950
☐ CHARLOTTE: 336-663-0143	☐ DELAWARE: 302-596-8553	☐ KANSAS CITY: 844-900-1292	☐ NORTHWEST AR: 888-615-1445	☐ SARASOTA: 941-870-6550
☐ CHICAGO: 312-253-7244	☐ EAST TN: 615-425-7427	☐ LAKELAND: 863-316-3910	☐ ORLANDO: 844-946-0867	☐ SOUTH JERSEY: 856-519-5309
☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ LITTLE ROCK: 501-451-5644	☐ PALM BEACH: 561-768-9044	☐ SOUTHWEST FL: 813-283-9144
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	☐ HOUSTON: 832-631-9595	☐ MIDDLE TN: 888-615-1445	☐ PIEDMONT TRIAD: 336-790-2200	☐ WEST TN: 888-615-1445