Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE	
☐ Relapsing-Remitting multiple sclerosis	ICD-10 Code: G35.A
☐ Primary Progressive multiple sclerosis, unspecified	ICD-10 Code: G35.B0
☐ Active secondary progressive multiple sclerosis	ICD-10 Code: G35.C1
☐ Multiple sclerosis, unspecified	ICD-10 Code: G35.D

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ Hepatitis B Test Results: Hep B surface antigen & Hep B Core **TOTAL** Antibody ☐ Liver Function Test results
List Tried & Failed Therapies 1)	2)

PREMEDICATION ORDERS

☐ acetaminophen (Tylenol) PO ☐ 500mg ☐ 650mg ☐ 1000mg

☐ diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)

☐ methylprednisolone (Solu-Medrol) IV ☐ 60mg ☐100mg ☐ 125mg ☐ _____ mg

☐ Other:

Manufacturer recommends pre-medicate with a corticosteroid and antihistamine at least 30 minutes prior to each injection

MEDICATION ORDERS

☒ 920mg ocrelizumab and 23,000 units hyaluronidase SQ in the abdomen over 10 min every 6 months

Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____

**(if not indicated order will expire one year from date signed)*

SPECIAL INSTRUCTIONS

☐ Urine pregnancy test prior to dose

☒ Monitor for at least 1 hour following first injection; monitor for at least 15 minutes following subsequent injections

☒ Do not administer remaining priming volume in SUBQ infusion set

Do **NOT** substitute ocrelizumab (for IV administration) and ocrelizumab/hyaluronidase (for SUBQ administration); products are **NOT** interchangeable.

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

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Revised 10/1/25