



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE, if applicable)

- | | |
|--|---|
| <input type="checkbox"/> G35.A Relapsing Remitting Multiple Sclerosis | <input type="checkbox"/> G35.C0 Secondary Progressive Multiple Sclerosis, unspecified |
| <input type="checkbox"/> G35.B0 Primary Progressive Multiple Sclerosis, unspecified | <input type="checkbox"/> G35.C1 Active Secondary Progressive Multiple Sclerosis |
| <input type="checkbox"/> G35.B1 Active Primary Progressive Multiple Sclerosis | <input type="checkbox"/> G35.C2 Non-active Secondary Progressive Multiple Sclerosis |
| <input type="checkbox"/> G35.B2 Non-active Primary Progressive Multiple Sclerosis, unspecified | <input type="checkbox"/> G35.D Multiple Sclerosis, unspecified |

REQUIRED: Demographics & Most Recent: H&P, clinical notes, lab results & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

Lab Results: Include Hepatitis B (if positive, provide documented medical treatment or clearance) and serum Immunoglobulins (IgG, IgM, IgA) prior to first dose

PRESCRIPTION

Pre-medications

- | | |
|---|--|
| <input type="checkbox"/> Acetaminophen: 650 mg PO | <input type="checkbox"/> Acetaminophen: _____ mg PO |
| <input type="checkbox"/> Cetirizine 10 mg PO | <input type="checkbox"/> Famotidine: _____ mg IV |
| <input type="checkbox"/> Dexamethasone: _____ mg IV | <input type="checkbox"/> Loratadine 10 mg PO |
| <input type="checkbox"/> Diphenhydramine: 25 mg PO | <input type="checkbox"/> Methylprednisolone: _____ mg IV |
| <input type="checkbox"/> Diphenhydramine: 25 mg IV | <input type="checkbox"/> Ondansetron: 4 mg IV |
| <input type="checkbox"/> Other: _____ | |

Lab Orders

- CBC w/diff: every _____ weeks month
 CMP: every _____ weeks month
 Other: _____

Ocrevus (ocrelizumab) IV

Loading Dose (select one)

- IV: infuse 300mg at weeks 0 and 2, then 600mg once every 6 months x 1 year

Maintenance (select one)

- IV: infuse 600mg once every 6 months x 1 year
 Other: _____

Ocrevus Zunovo (ocrelizumab/hyaluronidase) SQ infusion (select one)

- SQ: Inject 23 mL (ocrelizumab 920mg and hyaluronidase 23,000 units) subcutaneously in the abdomen over 10 min once every 6 months x 1 year

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

**** Patient will be observed for 1 hour after initial dose of Ocrevus Zunovo and for 15 min post-injection for all subsequent doses. ****

Is the patient on any other disease modifying therapy? Yes No

If yes, please note therapy and last dose: _____

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI # _____ Specialty: _____
 Office phone #: _____ Office Fax #: _____