

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

- G35.A Relapsing-Remitting MS (RRMS) G35.B2 Non-Active Primary Progressive MS (PPMS)
 G35.B0 Primary Progressive MS (PPMS), unspecified G35.C1 Active Secondary Progressive MS (SPMS)
 G35.B1 Active Primary Progressive MS (PPMS) G35.D Multiple Sclerosis, unspecified

ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- Insurance Information List of Medications Tried & Failed Therapies Most Recent History & Physical
 Negative Hepatitis B Quantitative Serum IG screening

MEDICATION ORDER

LOADING: Ocrevus Zunovo® 920 mg/23,000U in 23 mL subcutaneously over approximately 10 minutes every 6 months

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE:

Patient to be observed for 60 minutes following first administration and for 15 minutes following subsequent doses. Administer per protocol. In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRE-MEDICATIONS

RECOMMENDED

- Acetaminophen: 500 mg PO
 Dexamethasone: 20 mg PO
 Diphenhydramine: 25 mg PO

OTHER: _____ PO IV

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN