

✂ Please cut along the dotted lines before submitting to a pharmacy.

Date Required: \_\_\_\_\_ Ship To: \_\_\_\_\_ Patient \_\_\_\_\_ MD Office \_\_\_\_\_ Other: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
Contact Person: \_\_\_\_\_

**INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)**

Primary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
Prescription Card: \_\_\_\_\_ ID: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_

**To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:**

**DIAGNOSIS/CLINICAL INFORMATION**

**Primary Diagnosis:**  
G35.A Relapsing-remitting multiple sclerosis  
G35.B0 Primary progressive multiple sclerosis, unspecified  
G35.B1 Active primary progressive multiple sclerosis  
G35.B2 Non-active primary progressive multiple sclerosis  
G35.C0 Secondary progressive multiple sclerosis, unspecified  
G35.C1 Active secondary progressive multiple sclerosis  
G35.C2 Non-active secondary progressive multiple sclerosis  
G35.D Multiple sclerosis, unspecified  
Other ICD-10: \_\_\_\_\_

Number of Relapses the past year: \_\_\_\_\_  
Date of Diagnosis: \_\_\_\_\_  
Labs to be drawn: \_\_\_\_\_  
Frequency: \_\_\_\_\_

Therapy:  New  Reauthorization  Restart  
Date of last infusion with Ocrevus®: \_\_\_\_\_ Next dose due: \_\_\_\_\_  
Patient Weight: \_\_\_\_\_ kg lbs Height: \_\_\_\_\_ cm in  
Allergies: \_\_\_\_\_  
Concomitant Medications: \_\_\_\_\_  
Comorbidities: \_\_\_\_\_  
Required laboratory documents prior to first dose:  
Hepatitis B virus screening Documents:  
Negative  
Positive (Contraindicated)  
LFTs (ALT, AST, alkaline phosphatase, and bilirubin levels)  
Quantitative serum immunoglobulin IgG, IgA, IgM

**PRESCRIPTION INFORMATION**

<b>Medication:</b> Ocrevus Zunovo®	<b>Directions:</b> 920mg / 23,000 units Hyaluronidase (23mL) subcutaneously in the abdomen over approximately 10 minutes every 6 months by Health Care provider. Monitor for at least 1 hour post-injection for the initial dose then at least 15 minutes post-injection for subsequent doses.	<b>Quantity/Refills:</b> Dispense: 1 month supply Refills: 1 no refill
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**PREMEDICATION ORDERS/OTHER MEDICATIONS**

**Recommended Premedications & Other Medications**

Acetaminophen 650mg PO 30 min prior to infusion  
Diphenhydramine 50mg PO or Loratidine 10mg PO 30 min prior to infusion  
Dexamethasone 20mg PO 30 min prior to infusion  
Other: \_\_\_\_\_

Infusion supplies as per protocol  
Anaphylaxis kit orders as per protocol

**STAMP SIGNATURE NOT ALLOWED**

**PHYSICIAN SIGNATURE REQUIRED**

X \_\_\_\_\_  
**DISPENSE AS WRITTEN** (Date)