

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

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ Gender: _____	DEA #: _____ NPI #: _____
Emergency Contact: _____ Phone: _____	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		
Medication: Ocrevus Zunovo®	Directions: 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.	Quantity/Refills: Dispense: ☐ 1 month supply Refills: ☐ 1 ☐ no refill

PREMEDICATION ORDERS/OTHER MEDICATIONS	
Recommended Premedications & Other Medications ☐ Acetaminophen 650mg PO 30 min prior to injection ☐ Diphenhydramine 50mg PO or ☐ Loratidine 10mg PO 30 min prior to injection ☐ Dexamethasone 20mg PO 30 min prior to injection ☐ Other: _____	☐ Injection supplies as per protocol ☐ Anaphylaxis kit orders as per protocol

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

X _____
 DISPENSE AS WRITTEN (Date)