

Ocrelizumab and hyaluronidase-ocsq (Ocrevus Zunovo)

Provider Order Form rev. 8/24/26



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Mobile Phone Number: _____
Weight (lbs/kg): ☐ NKDA Allergies: _____
Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION (Please include the following with the order to support processing & insurance approval)

- Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)
- Hepatitis B results: If Hepatitis B results are positive, provide documentation of medical clearance
- Quantitative serum immunoglobulin screening • Liver Function Tests

DIAGNOSIS ICD-10 CODE (Provider must specify)

- | | |
|---|--|
| ☐ 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: _____ |

PRIMARY MEDICATION ORDER

Ocrelizumab and hyaluronidase-ocsq (Ocrevus Zunovo) 920mg/23,000units subcutaneous infusion every 6 months

- Administer over 10 minutes
- Monitor patients for at least one hour after the initial injection, and for at least 15 minutes after subsequent
- Refill for 12 months unless otherwise noted: _____

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: Recommendations per PI are selected, these will be given to patient unless otherwise specified.

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

☐ cetirizine (Zyrtec) 10mg PO

☒ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ PO

☒ Dexamethasone 20mg PO

☐ Other: _____

Dose: _____ Route: _____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print)

Provider Signature

Provider NPI

Date

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: _____	Referral Coordinator Email: _____
Referring Practice Name: _____	Phone: _____ Fax: _____
Practice Address: _____	City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS (Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)

☐ Arbor Infusion Fishers (317) 981-1772