INTRAMED Plus
infusion services

# OCREVUS®/OCREVUS ZUNOVO™

## INFUSION & MEDICAL CENTER

**1. Patient Name** _____ **DOB** _____ **Patient Phone/Cell #** _____

**Patient demographic and insurance information to be faxed with Infusion Order Form**

## 2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis: _____ Multiple sclerosis (MS) ICD-10 Code: G35

_____ Other _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

## 3. Clinical Information — Please fax with Infusion Order Form:

- Clinical documentation supporting primary diagnosis
  - o Include documentation of any previously trialed and/or failed therapies
- Recent Lab/Test Results including:
  - o Hepatitis B virus screening
  - o Quantitative serum immunoglobulin screening (including IgM, IgA, IgG)
- Medication List

**Patient**
**Weight:** _____ lbs.
**Height** _____ in.

## 4. Drug Order:

| ❑ **OCREVUS®** JCode: J2350 (ocrelizumab) | ❑ **OCREVUS ZUNOVO™** JCode: J____ (ocrelizumab and hyaluronidase-ocsq) |
|---|---|
| ❑ **Loading Dose:** Administer 300 mg IV over 2.5 hours on week 0 & 2 **Doses authorized:** 2* 300mg | **Dose:** 920 mg/23,000 units (23 mL total) |
| ❑ **Maintenance Dose:** Administer 600 mg IV over 2 hours (or 3.5 hours) once every 6 months **Doses Authorized:** 2 * 600mg | Infuse subcutaneously via pump over approximately 10 minutes once every 6 months **Doses Authorized:** 2 (two) |
| **Pre-medicate:** 30 minutes prior to infusion<br>- Acetaminophen 650 mg PO<br>- Diphenhydramine 50 mg IV<br>- Methylprednisolone 125 mg IV<br>- Other: _____ | **Pre-medicate:** 30 minutes prior to infusion<br>- Acetaminophen 650 mg PO<br>- Cetirizine 10 mg PO<br>- Dexamethasone 20 mg PO (or equivalent corticosteroid)<br>- Other: _____ |
| ❑ Famotidine 20 mg IV (check box if ordering) | |

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

**5. Physician Signature:** _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

| FAX ALL INFORMATION | CENTRAL INTAKE PHONE |
|---|---|
| CENTRAL FAX **803.999.1754** | **803.999.1750** |