Hackensack	Princeton / Somerset	Long Branch	Marlton
385 Prospect Avenue Suite 101 Hackensack, NJ, 07601	49 Veronica Avenue Suite 202 Somerset, NJ 08873	422 Morris Avenue Suite 7 Long branch, NJ 07740	127 Church Road Suite 600 Marlton, NJ 08053

Office: 212-803-3339 Fax : 646-768-8600

OCREVUS ZUNOVO™
(ocrelizumab and hyaluronidase-ocsq)

Date: ____________________

PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M ☐ F ☐
☐NKDA Allergies:		Weight lbs/kg:	

PHYSICIAN INFORMATION

Physician Name:	Practice Name:	
Address:	Office Contact Name:	Office Contact #:
Phone: Fax:	Email (for updates):	

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

OCREVUS ZUNOVO is a CD20-directed cytolytic antibody indicated for the treatment of:

- Relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults (1)
- Primary progressive MS, in adults (1)

☐ **ICD-10*:** ____________________
☐ **Dx Code:** ____________________
☐ **Dx Code:** ____________________

PRE-MEDICATION

☐ Tylenol PO 650mg ☐1000mg ☐other ______________
☐ Solumedrol 125mg IV ☐other ______________
☐ Benadryl ☐IVor ☐PO ☐25mg ☐50mg ☐other _________
☐ Dexamethasone ☐20mg IV ☐20mg ☐PO ☐other _________
☐ Desloratadine ☐5mg ☐PO
☐ ____________________ *(other)* ☐ ____________________ *(other)*

DIAGNOSIS *Please provide ICD-10 code*

☐ G35-MS

WARNINGS AND PRECAUTIONS

hhttps://www.gene.com/download/pdf/ocrevus_zunovo_prescribing.pdf

OCREVUS ZUNOVO ORDERS

PATIENT WEIGHT

_________ lbs.
_________ kg

DOSAGE:

☐ Injection 920mg ocrelizumab and 23,000 units of hyaluronidase per 23ml (40 mg and 1,000 units/mL) solution in a single-dose vial

FREQQUENCY:

☐ Every 6 months for __________ month
☐ Other: ______________________

LAB DRAW REQUEST

☐ Labs: ________________
☐ Freq:________________

NOTES/ADDITIONAL COMMENTS:

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Recent labs to **include Hepatitis Panel and CBC,** as well as CMP and quantitative, if available
*Please send any other recent labs
_____ Recent Progress note and MRI of Brain
_____ Other

ORDERING PROVIDER

Signature **X** ______________________________ Date __________

Provider ____________________ Phone __________ Fax __________

Diagnosis Code: ____________________
Order/dosage: ____________________
Signature: ____________________