OCREVUS ZUNOVO (ocrelizumab and hyaluronidase-ocsq) ORDER FORM

PATIENT NAME:_____ DOB:_____ WT:_____ HT:_____

ALLERGIES:_____

DIAGNOSIS

HAS THE PATEINT PREVIOUSLY RECEIVED: OCREVUS ZUNOVO (ocrelizumab and hyaluronidase-ocsq)   ❒NO   ❒YES

BRAND:_____ LAST DOSE DATE:_____

DIAGNOSIS:_____ ICD 10 CODE(S):_____

MEDICATION ORDERS

DOSE/FREQUENCY:
- ❒   920 mg ocrelizumab/23,000 units hyaluronidase sub-Q over 10 minutes every 6 months (use in abdomen only)
- ❒   Other: _____

PREMEDICATION: 30 minutes prior to injection
- ❒   Acetaminophen 1000 mg PO
- ❒   Acetaminophen 500 mg PO
- ❒   Dexamethasone 20 mg PO
- ❒   Other (include dose and route): _____
- ❒   Cetirizine 10 mg PO

Orders are valid for 1 year. For a shorter duration, indicate here:_____

STANDARD IV ORDERS

ANCILLARY ORDERS:
- Infusion Reaction Management per Infusion Solutions Protocol.
- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:
- If no central IV access, RN to insert peripheral IV.
- Obtain weight before each dose
- Monitor vital signs (temp, HR, RR, BP) before therapy, and every 15-30 minutes or with each rate change.
- If an infusion reaction occurs, decrease rate AND monitor vital signs until symptoms subside. If the reaction persists or worsens, stop the infusion, initiate reaction protocol, and notify physician.
- Observe patient for 30 minutes after completion of therapy.

LABS

LAB ORDERS:
- ❒   CBC w/ diff   ❒   CMP   ❒   CRP
- ❒   Serum immunoglobulins   ❒   Other: _____

LAB FREQUENCY:
- ❒   Every dose
- ❒   Other: _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:
- Hepatitis B serology labs
- Serum Immunoglobulin labs
- Documentation if patient has an active infection

RECOMMENDED CLINICAL DOCUMENTS (provide if available):
- Baseline labs (CBC w/ diff, CMP, CRP)

SUPPORTING DOCUMENTS:
- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

_____
PRESCRIBER SIGNATURE (substitution)

_____
PRESCRIBER SIGNATURE (dispense as written)

_____
PRINT NAME (FIRST AND LAST)

_____
DATE

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[Revised 4.10.25]

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