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®** (ocrelizumab) JCode: J2350	❑ **OCREVUS ZUNOVO™** (ocrelizumab and hyaluronidase-ocsq) JCode: J2351
❑ **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 - Acetaminophen 650 mg PO - Diphenhydramine 50 mg IV - Methylprednisolone 125 mg IV - Other: _____	**Pre-medicate:** 30 minutes prior to infusion - Acetaminophen 650 mg PO - Cetirizine 10 mg PO - Dexamethasone 20 mg PO (or equivalent corticosteroid) - 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	**INFUSION CENTER LOCATIONS**
CENTRAL FAX 803.999.1754	**BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**