Ocrevus® and Ocrevus Zunovo™

Provider Order Form Rev. 05/2025

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Multiple Sclerosis, G35

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Ocrevus® (ocrelizumab)	☐ **INITIAL:** 300 mg ☐ **MAINTENANCE:** 600 mg	☐ **INITIAL:** Infuse 300mg IV over 2.5 hours at Weeks 0 and 2 ☐ **MAINTENANCE:** Infuse 600mg IV over 3.5 hours every 6 months x 1 year ☐ **MAINTENANCE:** Infuse 600mg IV over 2 hours every 6 months x 1 year *Observe patient for 1 hour after completion of infusion.
Ocrevus Zunovo™ (ocrelizumab and hyaluronidase-ocsq)	☐ 23 mL (ocrelizumab 920 mg and hyaluronidase 23,000 units)	☐ Infuse SC in the abdomen over 10 minutes every 6 months x 1 year *Observe patient for 1 hour after initial dose and for 15 minutes post-injection for all subsequent doses.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

- Acetaminophen 650mg PO 30 minutes prior to infusion
- Diphenhydramine 25mg/50mg PO 30 minutes prior to infusion
- **For Ocrevus:** Methylprednisolone 100mg IV 30 minutes prior to infusion
- **For Ocrevus Zunovo:** Dexamethasone 20mg PO 30 minutes prior to infusion

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI: _____ TIN: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient has an MRI of the brain and/or spinal cord consistent with diagnosis of Multiple Sclerosis (MS).

☐ Physician documentation clearly indicates specific type of MS.

Please specify: ☐ Relapsing form of MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease

☐ Primary progressive MS (PPMS)

For Anthem BCBS only:

Physician documentation supports the following:

For relapsing form of MS:

☐ Patient can ambulate without aid or rest for ≥100 meters.

☐ If initiating therapy, patient has experienced at least two relapses within the previous 2 years or one relapse within the previous year.

For PPMS:

☐ Patient can ambulate >5 meters (not considered wheelchair bound.

LAB AND TEST RESULTS (required)

- Hepatitis B Screening (submit results to start therapy)
- Copy of recent MRI

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____