

Ocrevus Zunovo™ (ocrelizumab and hyaluronidase-ocsq) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

New Referral Updated Referral Referral Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:		Patient Email:
NKDA Allergies:	Weight (lbs/kg):	Height:
ICD-10 Code (required): SEE BELOW	Last Infusion Date:	Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

STANDING ORDERS

Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

- CBC w/ diff every _____
- CMP every _____
- Hepatic Function Panel every 6 months
- Quantitative IgG Levels every 12 months
- Vitamin D-25-OH every 12 months

***Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policy*

PREMEDICATIONS

****It is recommended to pre-medicate orally with 20 mg of dexamethasone (or an equivalent corticosteroid) and an antihistamine****

- acetaminophen (Tylenol) 500mg 650mg 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg 50mg PO IV
- dexamethasone 20mg PO
- Other: _____
- Dose: _____ Route: _____

OCREVUS ZUNOVO ADMINISTRATION

920 mg/23,000 units (920 mg ocrelizumab and 23,000 units of hyaluronidase) administered as a single 23 mL subcutaneous injection in the abdomen over approximately 10 minutes every 6 months

REQUIRED ICD-10 CODE

- G35.A Relapsing-remitting multiple sclerosis
- G35.B0 Primary progressive multiple sclerosis, unspecified
- G35.B1 Active primary progressive multiple sclerosis
- G35.B2 Non-active primary progressive multiple sclerosis
- G35.C0 Secondary progressive multiple sclerosis
- G35.C1 Active secondary progressive multiple sclerosis
- G35.C2 Non-active secondary progressive multiple sclerosis
- G35.D Multiple sclerosis, unspecified

REQUIRED DOCUMENTATION

- | | |
|------------------------------|-------------------------------------|
| Patient Demographics | HepB Surf Ag (within 12 months) |
| Insurance Card/Information | Hep B Core AB (within 12 months) |
| Progress Notes Supporting DX | Current Medication List and H&P |
| Quantitative Immunoglobulin | Liver function tests with bilirubin |

Provider Name (Print) Provider Signature Date

Email Referrals To: referrals@vivoinfusion.com OR Fax Below			Have a Question? Call (720) 902-4111	
Colorado: 303-418-4679	Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Oklahoma: 918-770-4421	Virginia: 804-500-5941
Connecticut: 203-724-4838	Michigan: 833-957-2188	New York: 800-540-1852	Pennsylvania: 215-399-9244	Wisconsin: 414-600-5383
Florida: 904-930-4211	Minnesota: 763-290-0903	Ohio: 216-400-0674	Texas: 469-340-0044	

****Order is valid for one year unless otherwise noted.****

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