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 Treatment 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

☐ Insurance Card/Information

☐ Progress Notes Supporting DX

☐ Quantitative Immunoglobulin

☐ HepB Surf Ag (within 12 months)

☐ Hep B Core AB (within 12 months)

☐ Current Medication List and H&P

☐ Complete Metabolic Panel

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
Connecticut: 203-724-4838
Florida: 904-930-4211
Massachusetts: 781-202-1629
Michigan: 833-957-2188
Minnesota: 763-290-0903
New Jersey: 609-955-3711
New York: 800-540-1852
Ohio: 216-400-0674
Oklahoma: 918-770-4421
Pennsylvania: 215-399-9244
Texas: 469-340-0044
Virginia: 804-500-5941
Wisconsin: 414-600-5383

Order is valid for one year unless otherwise noted.

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