



Patient Information	
Name:	_____
DOB:	_____
Address:	_____
City:	State: _____
Zip:	Weight: _____
Phone:	_____
Allergies:	_____

Prescriber Information	
Prescriber Name:	_____
NPI:	_____
Address:	_____
City:	_____
State:	Zip: _____
Phone:	_____

Diagnosis (please provide ICD-10 code in space provided):	
_____	Multiple Sclerosis
_____	Other: _____
Type Of MS:	_____
	Relapsing Remitting
	Primary Progressive
	Other: _____

Nursing Orders: Hold infusion and notify provider for:

Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles

If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Premedications:	
<input type="checkbox"/>	Tylenol 650mg PO
<input type="checkbox"/>	Loratadine 10mg PO
<input type="checkbox"/>	Benadryl 25mg IV or PO
<input type="checkbox"/>	Solu-Medrol 40mg, 125mg or ____ mg
<input type="checkbox"/>	Other: _____
Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.	

Ocrevus Zunovo SQ	Administer 23 mL (920 mg ocrelizumab and 23,000 units hyaluronidase) as a single subcutaneous injection in the abdomen over approximately 10 minutes every 6 months. Other: _____
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Prescriber Name (Please print): _____
Prescriber Signature: _____ Date: _____

Please include a copy of the latest insurance information as well as all applicable clinical notes.

Email to: orders@alliedinfusion.com Fax to: 832-698-3961