TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

OCREVUS ZUNOVO™

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Please Send a Copy of The Patient's up-to-Date Clinical Notes

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

CLINICAL INFORMATION

☐ 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, unspecified

☐ G35.C1 Active secondary progressive multiple sclerosis

☐ G35.CD Non-active secondary progressive multiple sclerosis

☐ G35.D Multiple sclerosis, unspecified

☐ Other (Specify ICD-10 Code): _____

Date of Last MRI: _____ Past DMT Therapies: _____

Hepatitis B (HBsAg and anti-HBV) Test Results: ☐ Positive ☐ Negative Quantitative Serum Immunoglobulins Test Results: _____

Date of last treatment with an OCREVUS product (if applicable) (MM/DD/YYYY): _____/_____/_____

ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Quantity/Refills
☐ OCREVUS ZUNOVO™ (920mg/23mL)	☐ 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 ☐ Other: _____	☐ Quantity: 1 Vial Refills: _____

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Cetirizine	☐ 10mg	☐ Take 1 tablet PO prior to infusion or as directed
☐ Dexamethasone	☐ 20mg	☐ Take 1 tablet PO prior to infusion or as directed
☐ _____	_____	_____

INFUSION REACTION ORDERS

Mild reaction protocol:

☒ Diphenhydramine 25mg IV, one time, for pruritus.

If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

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☒ Acetaminophen 650mg PO, one time, for pyrexia or rigors

☒ Diphenhydramine 50mg IV, one time, for pruritus or urticaria

☒ Famotidine 20mg IV, one time, for, for pruritus or urticaria

☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

☒ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

☒ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis

☒ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

☒ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:	**Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:**
☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	☒ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:	**PICC:**	**Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:**
☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	☒ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	☒ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused**

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.