Ocrelizumab (Ocrevus)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: . DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Multiple Sclerosis: ☐ RRMS ☐ PPMS ☐ SPMS

Other: Description:

THERAPY ADMINISTRATION & DOSING

☐ Induction: Administer Ocrevus 300 mg IV in 250 ml 0.9% normal saline on Week 0 and Week 2 followed by 600mg IV in 500 ml 0.9% normal saline 6 months after initial dose

☐ Maintenance: Administer Ocrevus 600 mg IV in 500 ml 0.9% normal saline every 6 months

☑ Observe patient for hypersensitivity reaction for a period of 60 minutes following each infusion.

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☑ Tylenol 500mg

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☑ Benadryl ☐ 25mg / ☑ 50mg ☐ PO / ☑ IVP

☑ Solumedrol 125mg IVP

☐ Other: _____

NURSING

☑ Must have negative hepatitis B and TB test prior to start

☑ Hold infusion and notify provider for:

- Signs/symptoms of infection or planned/recent surgery.
- recent live vaccines
- pregnancy or neurological symptoms.

☑ Monitor vital signs with every rate change, then every 30 minutes and prior to discharge.

☑ Patients on maintenance dosing who have not experienced a serious infusion reaction with any previous Ocrevus infusion may be eligible for an increased infusion rate. Reference quick notes for specifics on eligibility and dosing rate table.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, MRI results, Lesion number

Required Labs: Negative Hepatitis B

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.