

## Ocrelizumab (Ocrevus®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVe Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

<b>Patient Name:</b> _____ <b>Patient Address:</b> _____ <b>Patient Phone Number:</b> _____ <b>Date of Birth:</b> ____/____/____ <b>Weight:</b> ____ kg <b>Height:</b> ____ cm <b>Allergies:</b> _____	<b>Primary Insurance:</b> _____ <b>Member ID:</b> _____ <b>Secondary Insurance:</b> _____ <b>Member ID:</b> _____
<b>Diagnosis</b> Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	<b>Labs</b> No labs required. Labs to be ordered by physician. <input type="checkbox"/> Other: _____
<b>Date of negative Tuberculosis Screen:</b> _____ <b>Date of Negative Hepatitis Screen:</b> _____	
<b>Hold and notify provider:</b> Patient has signs/symptoms of an active infection.	
<b>Ocrelizumab (Ocrevus®)</b>  <input type="checkbox"/> Induction: 300 mg IVPB in 250 mL 0.9% sodium chloride on day 1 and 15 <input type="checkbox"/> Maintenance: 600 mg IVPB in 500 mL 0.9% sodium chloride every 6 months (26 weeks), beginning 6 months after the first 300 mg dose  <b>Nursing Note:</b> Observe patient for 1 hour following completion of each infusion. Administer through a dedicated IV line using a 0.2 or 0.22 micron in-line filter	
<b>Pre-Medications and Pre-Protocol</b> (ordered at physician discretion)	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input checked="" type="checkbox"/> Acetaminophen 650 mg PO prior to ocrelizumab  <input type="checkbox"/> Loratadine 10 mg PO once  <input checked="" type="checkbox"/> Diphenhydramine 30-60 minutes prior to ocrelizumab              <input checked="" type="checkbox"/> 25 mg    <input type="checkbox"/> 50 mg              <input type="checkbox"/> PO    <input checked="" type="checkbox"/> IV  <input type="checkbox"/> Famotidine 20 mg IV once  <input type="checkbox"/> Hydrocortisone 100 mg IV once  <input checked="" type="checkbox"/> Methylprednisolone 100 mg IVP 30-60 minutes prior to ocrelizumab  <input type="checkbox"/> Other: _____           </div> <div style="width: 35%; text-align: center;"> <b>Hydration</b>   <input type="checkbox"/> LR  <input type="checkbox"/> Sodium Chloride 0.9%  <input type="checkbox"/> Other: _____             _____ mL at _____ mL/hr  <input type="checkbox"/> Before    <input type="checkbox"/> During    <input type="checkbox"/> Following           </div> </div>

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<b>Flushing Protocol</b> (pre and post medication)	<input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL as needed for line care	<input type="checkbox"/> Heparin _____ Units/mL _____ mL as needed for line care						
<b>Hypersensitivity Panel</b> Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	<ul style="list-style-type: none"> <li>• <b>Sodium chloride</b> 0.9% bolus 500 mL once as needed for hypotensive management (SBP &lt;90mmHg)</li> <li>• <b>Acetaminophen</b> 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping</li> <li>• <b>Albuterol</b> 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses</li> <li>• <b>Albuterol HFA</b> inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea</li> <li>• <b>Epinephrine</b> injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses</li> <li>• <b>Famotidine</b> injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> <li>• <b>Diphenhydramine</b> injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom</li> <li>• <b>Diphenhydramine</b> injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> <li>• <b>Hydrocortisone</b> sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> </ul>							
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Provider Name: _____</td> <td style="width: 50%;">Provider Signature: _____</td> </tr> <tr> <td>Attending Physician Name: _____</td> <td>Provider NPI: _____</td> </tr> <tr> <td>Office Phone Number: _____</td> <td>Office Fax Number: _____</td> </tr> </table> <p><i>(If ordering provider is an advanced practice practitioner)</i>  <i>Note: This order is valid for 12 months from date of physician signature.</i></p>			Provider Name: _____	Provider Signature: _____	Attending Physician Name: _____	Provider NPI: _____	Office Phone Number: _____	Office Fax Number: _____
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