Fax Form to: 330-294-2082

INDY INFUSION

Ocrelizumab (Ocrevus)

Provider Order Form *rev. 10/12/2022*

PATIENT INFORMATION

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

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

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

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per Nursing Procedures, including reaction management and post-procedure observation

☐ Hepatitis B status & date (list results here & attach clinicals):
_____

Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Ocrevus induction.

☐ I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals):
_____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ famotidine (Pepcid) 20mg PO
☐ methylprednisolone (Solu-Medrol) 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

THERAPY ADMINISTRATION

☑ **Ocrelizumab** (Ocrevus) intravenous infusion
☐ Induction:
- Dose: 300mg in 250ml 0.9% sodium chloride
- Frequency: on Day 1 and Day 15
- Rate: Start at 30ml/hr, increasing by 30ml/hr every 30 minutes to a maximum rate of 180ml/hr
- Duration should be at least 2.5 hours
- After induction, continue with maintenance dosing below

☐ Maintenance:
- Dose: 600mg in 500ml 0.9% sodium chloride
- Frequency: every 6 months from infusion 1 of initial dose

☑ Rate: Choose one:
- ☐ Infuse over 3.5 hours (Start at 40ml/hr, increase by 40ml/hr every 30 minutes, max 200ml/hr)
- ☐ Infuse over 2 hours (Start at 100ml/hr x15 min, 200ml/hr x15 min, 250ml/hr x30 min, 300ml/hr until completion)

NOTE: If rate not indicated and no prior serious infusion reaction with previous infusion, will infuse over 2 hours

☑ Flush with 0.9% sodium chloride at the completion of infusion
☑ Patient required to stay for 60-min observation post infusion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

*Hepatitis B virus and quantitative serum immunoglobulin screening are required before the first dose. *Pre-medicate with methylprednisolone (or an equivalent corticosteroid) and an antihistamine (e.g., diphenhydramine) prior to each infusion. *Monitor patients closely during and for at least one hour after infusion.

Provider Name (Print) **Provider Signature** **Date**

Please include the following information when submitting a referral for Ocrevus:
*Results of a Hepatitis B virus lab
*Quantitative serum immunoglobulin results
*Radiology results confirming diagnosis
*Clinicals to support one or more of the following:
*Patient has relapsing multiple sclerosis (RMS)
*Patient has primary progressive multiple sclerosis (PPMS)
*Patient has secondary progressive multiple sclerosis (SPMS)