St. Charles Health System Adult Ambulatory Infusion Order Ocrelizumab (OCREVUS)	Patient Name: Date of Birth: *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: ________________ **Allergies:** __________________________________
Weight: ____________kg **Height:** ___________ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE ______________________________
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

GUIDELINES FOR ORDERING:

1. Send FACE SHEET and H&P or most recent chart note.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. Anti-CD20 therapies can result in profound hypogammaglobulinemia along with increased infections in a subset of patients. Obtain baseline immunoglobulins: IgG, IgM, and IgA prior to initiation of treatment, before each cycle, and every 6 months x 2 after completion of treatment.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

☐ Hepatitis B surface antigen and core antibody test results scanned with orders
☐ IgG, IgM, and IgA prior to initiation of treatment, test results

LABS:

☐ CBC with auto differential, ONCE, every 6 months
☐ IgG, IgM, and IgA, ONCE, every 6 months
☐ Immunocompetency panel, ONCE, every 6 months

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive or if screening has not been performed.
2. RN to assess for active infection. If patient shows signs and symptoms of active infection or currently taking antibiotics. Hold treatment and notify provider
3. VITAL SIGNS – First and second infusions: Obtain vital signs at baseline, then every 30 minutes with rate escalation, then every 30 minutes for the duration of the infusion. Third infusion and beyond: Obtain vital signs at baseline, then every 30 minutes with rate escalation. If no previous infusion reaction, monitor vital signs every hour until infusion complete.
4. Monitor patient for Ocrelizumab infusion-related reactions for 1 hour after completion of first and second Ocrelizumab infusions. Monitoring not required for third infusion and beyond, if no

previous infusion reactions. Lengthened monitoring recommended for previous infusion reactions, contact provider for guidance

5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS (administer 30-60 minutes prior to infusion):
Premedication with methylprednisolone and an antihistamine are required.
(**Select both or provide a medical reason for deviation)**

☐ methylPREDNISolone sod suc(PF) (SOLU-Medrol) injection: 100 mg IV once, administer 30 minutes prior to each dose of ocrelizumab **(required)**

☐ diphenhydramine (Benadryl): 25 mg IV once, not to exceed 25 mg/min, 30 minutes prior each dose of ocrelizumab **(required)**

☐ Acetaminophen (Tylenol): 650 mg PO once, 30 minutes prior each dose of ocrelizumab (optional)

☐ cetirizine (Zyrtec) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. **Give either cetirizine or diphenhydrAMINE, not both.**

☐ Reason for deviation (if applicable): ________________________

MEDICATIONS:

☐ Ocrelizumab (OCREVUS) 300 mg in sodium chloride 0.9%, intravenous Every 2 weeks for 2 treatments

1. NURSING COMMUNICATION – For 300 mg infusions: Infuse Ocrelizumab via pump slowly at 30 mL/hr for the first half-hour. If no infusion related side effect is seen, increase rate gradually (30 mL/hour) every 30 minutes to a maximum of 180 mL/hour. If infusion not tolerated, STOP infusion, notify provider and administer appropriate hypersensitivity medications. When infusion related side effects have resolved begin the Ocrelizumab infusion at half the previous rate. Resume titrations with provider guidance.

☐ Ocrelizumab (OCREVUS) 600 mg in sodium chloride 0.9%, intravenous Every 6 months, until discontinued

1. NURSING COMMUNICATION – For 600 mg infusions: If previous infusion reaction, contact provider for rate guidance. If no previous infusion related side effects noted, infuse Ocrelizumab via pump at 100 mL/hr for the first 15 minutes. Increase to 200 mL/hr for the next 15 minutes. Increase to 250 mL/hr for the next 30 minutes. Increase to 300 mL/hr for the remaining 60 minutes. If infusion not tolerated STOP infusion, notify provider and administer appropriate hypersensitivity medications. When infusion related side effects have resolved begin the Ocrelizumab infusion at half the previous rate.

HYPERSENSITIVTY MEDICATIONS:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

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Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: ______________________________ License #: __________________ Date: ____________

Print Name: ____________________________ Phone: ___________________ Fax: ________________

Plan will expire 1 year after signature date at which time a new order will need to be placed