ORDERING OFFICE, ALSO FAX:

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

Ocrelizumab (Ocrevus)

Provider Order Form

IVX HEALTH formerly Infusion Express

Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
☐ NKDA Allergies:		Weight lbs/kg:
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:

NURSING

- ☑ Provide nursing care per IVX Standard Nursing Procedures, including reaction management and post-infusion observation
- ☑ Hepatitis B status and date (Please provide results) _____

LABORATORY ORDERS

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

PRE-MEDICATION ORDERS (ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ ranitidine (Zantac) ☐ 75mg PO / ☐ 150mg PO
- ☐ methylprednisolone (Solu-Medrol) 125mg IV
- ☐ Other:

  Dose: Route: Frequency:

INFUSION THERAPY

- ☑ 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 (24 weeks) from infusion 1 of initial dose
    - Rate: Start at 40ml/hr, increasing by 40ml/hr every 30 minutes to a maximum rate of 200ml/hr
    - Duration should be at least 3.5 hours
- ☑ Flush with 0.9% sodium chloride at the completion of infusion
- ☑ Patient is required to stay for 60 minute observation post infusion
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____(if not indicated order will expire one year from date signed)

GENERAL PLAN COMMUNICATION

Special instructions/notes:

Ordering Provider: Initial here _____ and proceed to the next page.

ADULT REACTION MANAGEMENT

- ☑ Observe for **hypersensitivity reaction:** Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation
- ☑ If reaction occurs:
  - Stop infusion
  - Maintain/establish vascular access
  - Notify referring provider
  - Consider giving the following PRN
    1. Acetaminophen (Tylenol) 650mg PO **OR**_____mg for pain or fever > 38 C/100.4 F
    2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
    3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
    4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
    5. Methylprednisolone (Solumedrol) 125mg **OR** _____mg slow IV push.
    6. Other _____
  - When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's guidelines

- ☑ **Severe allergic/anaphylactic reaction:**
  - If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
    1. Call 911
    2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
    3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
    4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
    5. Have Automated External Defibrillator available
    6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
    7. Discontinue treatment

Hepatitis B virus screening is 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

Patient Name _____ **Patient Date of Birth** _____

Provider Name (Print) _____

Provider Signature _____ **Date** _____

Designate the desired location and fax the order form to:

CALIFORNIA fax: (844) 889-0275 | ☐ San Mateo ☐ Fremont ☐ San Ramon ☐ TBD

ILLINOIS fax: (312) 253-7244 | ☐ Glenview ☐ Schaumburg ☐ TBD

KANSAS / MISSOURI fax: (844) 900-1292 | ☐ Overland Park, KS ☐ Lee's Summit, MO ☐ Briarcliff, MO ☐ TBD

OHIO fax: (844) 627-2675 | ☐ Dublin ☐ Pickerington ☐ TBD

PENNSYLVANIA fax: (844) 820-9641 | ☐ Malvern ☐ Bensalem ☐ Montgomeryville ☐ East Shore ☐ West Shore ☐ TBD

TENNESSEE fax: (844) 627-2518 | ☐ Brentwood ☐ Hendersonville ☐ TBD

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