ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800
Please mark the appropriate infusion center:

❑ Allenmore Infusion Center
❑ Auburn Infusion Center
❑ Gig Harbor Infusion Services
❑ Puyallup Infusion Center
❑ DHEC Infusion Center
❑ North Spokane Infusion Center
❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Ocrelizumab (OCREVUS):

Patient Name:____ Requested Date of Service: ________ /________ /________

Date of Birth: ______ /______ /_______ Patient Phone Number: (______) ________ - ____________________ ❑ May leave message

Diagnosis: ❑ Multiple Sclerosis
❑ Other___________________________

ICD -10 Code:
❑ G35
❑_______________________________________

Required: H&P with documentation to support above diagnosis including ICD-10 code
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline Labs Required:
- Hepatitis B Virus (HBV) screening prior to initiation of ocrelizumab therapy. Ocrelizumab is contraindicated in patients with active HBV confirmed by positive results for HBsAg and anti-HBV tests. For patients who are negative for surface antigen [HBsAg] and positive for HB core antibody [HBcAb+] or are carriers of HBV [HBsAg+], recommended to consult liver disease experts before starting and during treatment
- Latent TB testing completed:________________ Result:________________

Other Labs:
❑ **CBC, CMP prior to each infusion**___________________________
☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal

Treatment Regimens:
❑ **Initiation: Ocrelizumab 300 mg Day 1 & Day 15, then 600 mg every 6 months x 12 months**
❑ **Maintenance: Ocrelizumab 600 mg every 6 months x 12 months**
☑ Pre-meds given 30-60 minutes prior to ocrelizumab:
- Methylprednisolone 125 mg IV x 1 dose
- Acetaminophen 650 mg po x 1 dose
- Diphenhydramine 25 mg IV x 1 dose

Ocrelizumab infusion will be titrated per medication guidelines
Special instructions: Observe the patient for one hour after completion of the infusion
☑ Vital signs prior to and following completion of infusion.
Contact provider if systolic BP> 180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.)
- Consult MultiCare Hypersensitivity guideline for treatment/management
- Notify provider of reaction, assessment and need for further orders"

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

__________________________________ ______________________________ ________________ ________________
Provider Signature Print Name Date Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
Ocrelizumab (OCREVUS)

78-1326-9 (Rev. 9/24)