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 and Hyaluronidase (Ocrevus Zunovo®):

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis: ❑ Multiple Sclerosis **ICD -10 Code:** ❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation
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.
❑ Latent TB testing in high-risk populations or in countries with high TB burden
Date completed:_____ Results:_____
❑ Quantitative serum immunoglobulins
❑ CBC/CMP

Maintenance Labs:
❑ Quantitative serum immunoglobulins annually
❑ CBC/CMP every 6 months

Treatment Regimen:
❑ Ocrelizumab and Hyaluronidase 920 mg/23,000 units SUBQ every 6 months
Administer over approximately 10 minutes. Monitor patients closely during all injections, for at least one hour after the injection, and for at least 15 minutes after subsequent injections

Premeds:
❑ Dexamethasone 20 mg PO ❑ Loratidine 10 mg PO ❑ Acetaminophen 650 mg PO

☑ **Vital signs:** Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

If Hypersensitivity reaction (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

MULTIPLE SCLEROSIS

MultiCare