

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)**MultiCare** 

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