REDINGTON FAIRVIEW GENERAL HOSPITAL
Skowhegan, Maine 04976

Ocrelizumab (Ocrevus) Order Form

REQUIRED DOCUMENTATION attached: □ List of current medications and allergies.

Patient Weight: _____kg Height: _____inches

DIAGNOSIS: ☑ Multiple Sclerosis

LABS: Hepatitis B virus screening (HBsAg and anti-HBc) prior to therapy initiation required.

Date done_____ ☐Negative ☐Positive (treatment contraindicated)

Other: _____ ☐ each infusion ☐ other frequency_____

ORDERS:

1. Supply patient with the manufacturer/FDA Medication Guide.
2. Instruct patient of signs of infusion type reaction and to immediately report headache, difficulty breathing, chest pain or any discomfort. (See infusion guidelines for other types or reactions)
3. Assess for infection; delay administration for active infection.
4. Alteplase 2 mg to restore function of central IV access device, as needed, per RFGH procedure.
5. **Premeds to be given 30 minutes prior to infusion:**
   Required ☑ MethylprednisoLONE IV 100 mg IV
   ☐Loratadine 10 mg PO **-or-** ☐ Diphenhydramine PO 25 mg **- or-** _____ mg
   -or- ☐Diphenhydramine IV 25 mg **- or-** _____ mg
   Optional: ☐ Acetaminophen PO 650 mg **-or-** _____ mg
   ☐ Ibuprofen PO 400 mg **– or-** _____ mg ☐ Other: _____
6. **Ocrelizumab (Ocrevus) –** *New order required no less often than every 12 months.*
   ☐**New patient** 300 mg IV x 2, 2 weeks apart; then 600 mg IV 6 months later.
   ☐ **Continuation of treatment:** 600 mg IV every 6 months
7. Vital signs and titration per increase in rate RFGH policy "OCRELIZUMAB INFUSION PROCEDURE"
   OTHER:

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] Complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Name:_____

Checklist for non-RFGH credentialed providers:
[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, **call (207) 474-5121** and ask to speak to hospitalist . Contacted provider: _____
[ ] Problem list & medication list attached to orders.

Provider_____Date_____time_____

Printed name_____ Phone # _____
if above not-RFGH credentialed:

RFGH Co-signature _____ Date_____ time_____

Printed name_____
Reviewed 8/24
Copy: Pharmacy resources, Phillips vital sign template, rfgh.net
MT: Protocol – OCRELIZUMA, ONC.OCREVU
Order set - OCRELIZUMAB
Originator: pharmacy

Label or
Patient name_____

Date of birth_____

Patient phone number_____