

# Ocrelizumab (Ocrevus)



Provider Order Form rev. 10/12/2022

## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_  
 NKDA Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_  
Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_  
Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## NURSING

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation  
**NOTE:** IVX Adverse Reaction Management Protocol available for review at [www.ivxhealth.com/forms](http://www.ivxhealth.com/forms) (version 09.07.2021)
- Hepatitis B status & date (list results here & attach clinicals): \_\_\_\_\_

**Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Ocrevus induction.**

- I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals): \_\_\_\_\_
- I instruct IVX Health to draw quantitative serum immunoglobulin prior to first induction infusion (if required by payor).

## PRE-MEDICATION ORDERS

- acetaminophen (Tylenol)  500mg /  650mg /  1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl)  25mg /  50mg  PO /  IV
- famotidine (Pepcid) 20mg PO
- methylprednisolone (Solu-Medrol) 125mg IV
- hydrocortisone (Solu-Cortef)  100mg IV
- Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

## SPECIAL INSTRUCTIONS

## LABORATORY ORDERS

- CBC  at each dose  every \_\_\_\_\_
- CMP  at each dose  every \_\_\_\_\_
- CRP  at each dose  every \_\_\_\_\_
- Other: \_\_\_\_\_

## THERAPY ADMINISTRATION

- 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 from infusion 1 of initial dose
- Rate: Choose one:
  - Infuse over 3.5 hours (Start at 40ml/hr, increase by 40ml/hr every 30 minutes, max 200ml/hr)
  - Infuse over 2 hours (Start at 100ml/hr x15 min, 200ml/hr x15 min, 250ml/hr x30 min, 300ml/hr until completion)

**NOTE:** If rate not indicated and no prior serious infusion reaction with previous infusion, will infuse over 2 hours

- Flush with 0.9% sodium chloride at the completion of infusion
- Patient required to stay for 60-min observation post infusion
- Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

\*Hepatitis B virus and quantitative serum immunoglobulin screening are 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.

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

## FAX NUMBERS

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> BAY AREA: 844-889-0275       | <input type="checkbox"/> CHICAGO: 312-253-7244     | <input type="checkbox"/> HARRISBURG: 844-859-4235   | <input type="checkbox"/> PALM BEACH: 561-768-9044   | <input type="checkbox"/> TAMPA: 844-946-0849      |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143      | <input type="checkbox"/> COLUMBUS: 844-627-2675    | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN/AR: 888-615-1445 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868     | <input type="checkbox"/> DAYTONA: 386-259-6096     | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> RALEIGH: 919-287-2551      | <input type="checkbox"/> MIDDLE TN: 888-615-1445  |
| <input type="checkbox"/> FT. LAUDERDALE: 754-946-2052 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> ORLANDO: 844-946-0867      | <input type="checkbox"/> SARASOTA: 941-870-6550     | <input type="checkbox"/> EAST TN: 615-425-7427    |
|   |  |   | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 |   |