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| ADULT AMBULATORY INFUSION ORDER  **Ocrelizumab (Ocrevus)** | **NAME:**  **BIRTHDATE:**    *Affix Patient Identification Label Here* |
| **ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (**  **) TO BE ACTIVE.** | |

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

\***Please fax a copy of the** □Demographics □ Insurance Information □ Current Lab Results

**following patient information**: □ H & P Relevant to Diagnosis □ Last infusion note □ Current Medications

Provider Information

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs/kg Height: \_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_\_

Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hep B Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ □ Copy Attached

HIV Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ □ Copy Attached

Varicella Zoster Antibodies Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ □ Copy Attached

TB TEST: Quantiferon Gold or PPD results □ Positive □ Negative

Has patient had any immunizations in the last 3 months? □ Yes □ No

Pre-medications:

Diphenhydramine: □ IV □ 50mg

Acetaminophen: □ PO □ 1000 mg

Solu-Medrol: □ IV □ 1000 mg

Other: □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No Pre-Medications

□ 30 minutes wait time following pre-medications

Labs:

□ CBC w/diff □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ CMP □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ UA □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_\_□ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No labs needed

**Ocrevus Orders:**

* \*\*Use 0.2 micron filter for administration\*\*

* **Loading Dose: 300 mg IV in 250 mL in Sodium Chloride 0.9% to be infused on day 1 and day 15. Begin infusion at 30 mL/hour; increase by 30 mL/hour every 30 minutes to a maximum rate of 180 mL/hour.**
* **Maintenance: 600 mg IV in 500 mL in Sodium Chloride 0.9% 6 months after loading dose then every 6 months. Begin infusion at 100 mL/hour x 15 minutes; increase to 200 mL/hour x 15 minutes; increase to 250 mL/hour x 30 minutes; increase to a maximum rate of 300 mL/hour for remainder of the infusion.**

* **If any serious infusion reactions occur, use slower rate for 600 mg dose. Begin infusion at 40 mL/hour; increase by 40 mL/hour every 30 minutes to a maximum rate of 200 mL/hour.**
* **Patient is required to stay for 60 minute observation post infusion.**
* Patient is **NOT** required to stay for observation time.