

# Ocrelizumab (Ocrevus)

Provider Order Form rev. 1/23/2025



## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_  
Patient Address: \_\_\_\_\_ Patient Email: \_\_\_\_\_  
Allergies: \_\_\_\_\_  NKDA Weight (lbs/kg): \_\_\_\_\_ Height (in/cm): \_\_\_\_\_  
Sex:  M /  F Date of Last Infusion: \_\_\_\_\_ Next Due Date: \_\_\_\_\_ Preferred Location: \_\_\_\_\_

## DIAGNOSIS (Please provide ICD-10 code in space provided)

G35: Multiple Sclerosis  
Type:  RRMS  SPMS  PPMS  PRMS  CIS  
 Other: \_\_\_\_\_ Description: \_\_\_\_\_

## THERAPY ADMINISTRATION & DOSING

- Induction: Administer Ocrevus 300 mg IV in 250 ml 0.9% normal saline on Week 0 and Week 2 followed by 600mg IV in 500 ml 0.9% normal saline 6 months after initial dose
- Maintenance: Administer Ocrevus 600 mg IV in 500 ml 0.9% normal saline every 6 months
- Observe patient for hypersensitivity reaction for a period of 60 minutes following each infusion.

## ADDITIONAL ORDERS

## LABORATORY ORDERS

- CBC w/ diff  at each dose  every: \_\_\_\_\_
- Quantitative Serum Immune Globulin every 3 months
- Other: \_\_\_\_\_

## PRE-MEDICATION ORDERS

- Tylenol 500mg
- Loratadine 10mg PO
- Pepcid 20mg  PO /  IVP
- Benadryl  25mg /  50mg  PO /  IVP
- Solumedrol 125mg IVP
- Other: \_\_\_\_\_

## NURSING

- Must have negative hepatitis B and TB test prior to start
- Hold infusion and notify provider for:
  - Signs/symptoms of infection or planned/recent surgery.
  - recent live vaccines
  - pregnancy or neurological symptoms.
- Monitor vital signs with every rate change, then every 30 minutes and prior to discharge.
- Patients on maintenance dosing who have not experienced a serious infusion reaction with any previous Ocrevus infusion may be eligible for an increased infusion rate. Reference quick notes for specifics on eligibility and dosing rate table.
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

## PROVIDER INFORMATION

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

## REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, MRI results, Lesion number

**Required Labs:** Negative Hepatitis B

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.