**Trinity Health Muskegon & Shelby Infusion Clinics**
Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444
Shelby: 72 S. State St. Shelby, MI 49455
Fax: 231-727-4328

# Ocrelizumab (Ocrevus®)

*With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies*

**Order Date:** ____/____/____ **Site of Service:** TH Muskegon

**Referral Status**: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

| | |
|---|---|
| **Patient Name**: _____<br>**Date of Birth**: ____/____/____<br>**Weight:** _____kg **Height:** _____cm<br>**Allergies:** _____ | **Primary Insurance:** _____<br>**Member ID:** _____<br>**Secondary Insurance:** _____<br>**Member ID:** _____ |
| **Diagnosis**<br>Diagnosis Code (ICD-10): _____<br>Indication: _____<br>Target start date: _____ | **Labs**<br>No specific labs required. Lab to be ordered at physician discretion.<br>☐ Other: _____ |

**Date of Negative Hepatitis Screen: _____** **Date of negative Tuberculosis Screen: _____**

**Hold/Notify Physician for**: signs/symptoms of active infection.

**Pre-Medications**

☒ Diphenhydramine 25 mg IVP 30-60 minutes prior to Ocrelizumab.
☒ Acetaminophen 650 mg PO prior to Ocrelizumab
☒ Methylprednisolone 100 mg IV Push 30-60 minutes prior to Ocrelizumab
☐ Other: _____

## ℞ Ocrelizumab (Ocrevus®)

☐ **Induction: 300 mg IVPB on day 1 and 15**
☐ **Maintenance: 600 mg IVPB every 6 months (26 weeks), beginning 6 months after the first 300 mg dose**

Nursing Note: Observe patient for 1 hour following completion of each infusion. Administer through a dedicated IV line using a 0.2 or 0.22 micron in-line filter

**Nursing Orders:**

**Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary:**

sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN

Provider Name: _____ Provider Signature: _____
Office Phone Number: _____ Office Fax Number: _____
Attending Physician Name: _____
*(If ordering provider is an advanced practice practitioner, attending physician required)*
*Note: This order is valid for 12 months from date of physician signature.*