

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183

☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970

☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801

☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788

☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348

☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485

☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418

☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917

☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

**OUTPATIENT OCRELIZUMAB (OCREVUS)
ORDERS**

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Diagnosis: ☐ Multiple Sclerosis, Relapsing **ICD10:** _____
☐ Multiple Sclerosis, Primary Progressive ☐ Other: _____

Hepatitis B Testing: Hepatitis B: Date: ____/____/____ Result: _____

IV Access:

- ☐ Saline Lock:
☒ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
☒ Discontinue Saline Lock after therapy completed
- ☐ PICC Line:
☒ Routine PICC Line Care, labs and restoration
☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)
- ☐ Porta cath / Central Access Device (Hickman, Triple lumen):
☒ Porta cath access, labs, restoration and de-access / Central Access Device use and care

Height: _____ cm **Weight:** _____ kg

Premedication:

- ☒ Acetaminophen (Tylenol) 650 mg, PO, ONCE
☒ Cetirizine (Zyrtec) 10 mg, PO, ONCE
☒ Methylprednisolone (SoluMedrol) 125 mg, IVP, ONCE

PRN Medication:

- ☐ diphenhydramine (Benadryl) 25 mg, IVP, ONCE, PRN, Infusion related reaction

Medication:

Initial Dosing: (Days 1 and 15)

- ☐ Ocrelizumab (Ocrevus) **300 mg/250 mL 0.9% Sodium Chloride, Soln, IVPB**
1) Use 0.2 micron in-line filter 2) Start at 30 mL/hr 3) Increase by 30 mL/hr every 30 minutes to maximum of 180 mL/hr

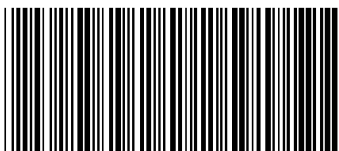
Day 1: Date: ____/____/____

Day 15: Date: ____/____/____

Subsequent Dosing: (at least 5 months after day 15 dose)

- ☐ Ocrelizumab (Ocrevus) **600 mg/500 mL 0.9% Sodium Chloride, Soln, IVPB**
1) Use 0.2 micron in-line filter
2) If initial dosing TOLERATED WITHOUT REACTION, administer over approximately 2 hours using following titration:
Initial rate = 100 mL/hour for 15 minutes; then 200 mL/hour for 15 minutes; then 250 mL/hour for 30 minutes; then 300 mL/hour for remaining 60 minutes
3) If HISTORY OF SERIOUS INFUSION REACTION with previous ocrelizumab infusion, administer over 3.5 hours or longer using following titration:
Initial rate = 40 mL/hour; then increase by 40 mL/hour every 30 minutes to maximum rate of 200 mL/hour

REPEAT subsequent dosing every: _____ months for: ☐ 6 months ☐ 1 year



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Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
July 2024