Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Ocrelizumab (OCREVUS) Infusion** Page 1 of 3	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****
**** Height, weight, and BSA are required for a complete order****

Scheduling instructions: Initial dose 300 mg, intravenous, x 2 doses, 14 days apart. Maintenance dose 600 mg, intravenous, starting 6 months after initial dose, every 6 months.

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

☐ Hepatitis B surface antigen and core antibody test results scanned with orders

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive or if screening has not been performed.
2. RN to assess for active infection. If patient shows signs and symptoms of active infection or currently taking antibiotics. Hold treatment and notify provider
3. VITAL SIGNS – First and second infusions: Obtain vital signs at baseline, then every 30 minutes with rate escalation, then every 30 minutes for the duration of the infusion. Third infusion and beyond: Obtain vital signs at baseline, then every 30 minutes with rate escalation. If no previous infusion reaction, monitor vital signs every hour until infusion complete.
4. Monitor patient for Ocrelizumab infusion-related reactions for 1 hour after completion of first and second Ocrelizumab infusions. Monitoring not required for third infusion and beyond, if no previous infusion reactions. Lengthened monitoring recommended for previous infusion reactions, contact provider for guidance
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

PRE-MEDICATIONS: (Administer 30-60 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.
Give either loratadine or diphenhydrAMINE, not both.
☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. **Give either loratadine or diphenhydrAMINE, not both.**
☐ methylPREDNISolone sodium succinate (SOLU-MEDROL), 100 mg, intravenous, ONCE, every visit

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Monoclonal Antibody:

☐ Ocrelizumab (OCREVUS) 300 mg in sodium chloride 0.9%, intravenous
Every 2 weeks for 2 treatments

Infuse per infusion plan nursing orders. Infuse through 0.2 micron inline filter. Do not shake

NURSING COMMUNICATION – For 300 mg infusions: Infuse Ocrelizumab via pump slowly at 30 mL/hr for the first half-hour. If no infusion related side effect is seen, increase rate gradually (30 mL/hour) every 30 minutes to a maximum of 180 mL/hour. If infusion not tolerated, STOP infusion, notify provider and administer appropriate hypersensitivity medications. When infusion related side effects have resolved begin the Ocrelizumab infusion at half the previous rate. Resume titrations with provider guidance

☐ Ocrelizumab (OCREVUS) **600 mg** in sodium chloride 0.9%, intravenous
Every 24 weeks, until discontinued

Infuse per infusion plan nursing orders. Infuse through 0.2 micron inline filter. Do not shake

NURSING COMMUNICATION – For 600 mg infusions: If previous infusion reaction, contact provider for rate guidance. If no previous infusion related side effects noted, infuse Ocrelizumab via pump at 100 mL/hr for the first 15 minutes. Increase to 200 mL/hr for the next 15 minutes. Increase to 250 mL/hr for the next 30 minutes. Increase to 300 mL/hr for the remaining 60 minutes. If infusion not tolerated STOP infusion, notify provider and administer appropriate hypersensitivity medications. When infusion related side effects have resolved begin the Ocrelizumab infusion at half the previous rate.

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for infusion reaction
3. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for rash, hypersensitivity or infusion reaction
4. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction
6. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction
7. meperidine (DEMOEROL) injection, 25-50 mg, intravenous, every 2 hours as needed for infusion-related severe rigors in the absence of hypotension. Not to exceed 50 mg/hr
8. sodium chloride 0.9% IV bolus, 1,000 mL, as needed for infusion related side effects

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By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders