***Conveniently Located in East Syracuse, Onondaga Hill & Auburn***
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

## Ocrevus (ocrelizumab) Non-Oncology Treatment Order Set

**1. Patient Name:** _____

**2. DOB:** _____ **Height (inches):** _____ **Weight (lbs):** _____

**3. Diagnosis:**

[ ] G35 Relapsing Remitting Multiple Sclerosis [ ] G35 Primary Progressive Multiple Sclerosis
[ ] Other ICD-10 Code: _____ Diagnosis description: _____

**4. Pre-medications:**

[ ] Acetaminophen:
[ ] **1000mg PO** [ ] **500mg PO**
[ ] Diphenhydramine:
[ ] **25mg PO** [ ] **50mg PO** [ ] **25mg IV** [ ] **50mg IV**
[ ] Hydrocortisone: 100mg IVP
[ ] Other Pre-medication: _____
[ ] No Pre-medications indicated

**5. Drug Order:**

**Ocrevus (ocrelizumab)** *Ok to substitute with generic/biosimilar*
[ ] **Induction dosing:** 300mg IV at week 0 & repeat again week 2.
[ ] **Maintenance dosing:** 600mg IV every 6 months
Special Instructions: _____
[ ] **New to Therapy**
[ ] **Continuing therapy:** Last Dose Received _____ Next Dose Due _____

*HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral*

**6. Infusion Lab Requirements:**

[ ] CBC & CMP within 30 days prior to infusion
[ ] Other: _____
[ ] No lab monitoring

*HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.*
*The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.*

7. **Required Baseline Lab/Testing have been completed**:

[ ] Hepatitis B sAG, sAB & core AB total, date: _____ [ ] CBC/CMP, date: _____ [ ] Other: _____

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

7. **Physician's Name**: _____ **Phone:** _____
**Physician's Signature**: _____**Date:** _____

***(This drug administration order form is valid for 12 months)***