



# Ocrelizumab (OCREVUS)

6955 Foothill Blvd, Suite 67A, Oakland, CA, 94605

Phone: (510) 878-9528 | Fax: (510) 969-5840 | Email: referrals@totalinfusion.com

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Gender:  Male  Female

Allergies: \_\_\_\_\_

### DIAGNOSIS (ICD-10 code required):

- \_\_\_\_\_ Multiple Sclerosis
- Other: \_\_\_\_\_

### PROVIDER REMINDERS:

- All orders with a  will be placed unless otherwise noted
- Screen for viral hepatitis
- Complete any required live or live-attenuated vaccinations at least 4 weeks and non-live vaccinations at least 2 weeks prior to initiation of therapy
- Varicella immune screen, urinalysis, and urine culture before treatment start day (continue urinalysis and urine culture prior to each treatment if patient has a history of bladder infections)
- CBC w/diff and Serum Immunoglobulins (IgG, IgM, IgA) prior to treatment

### TREATMENT CRITERIA:

Hold Ocrelizumab (OCREVUS) if:

- Temperature **GREATER THAN** 100 degrees F
- Complains of symptoms of acute viral or bacterial illness
- Taking antibiotics for current infection
- *Initial dose only:* Unable to verify negative HBV results

Notify Provider if:

- CBC w/diff and Serum Immunoglobulins are not drawn prior to infusion
- New or worsening neurological symptoms, such as memory loss, trouble thinking, dizziness, loss of balance, loss of vision, difficulty talking or walking

Nursing Considerations:

- Monitor for adverse reaction, including vital signs and pulse ox, every 30 minutes until max infusion rate achieved, then at the end of infusion, and one hour post infusion

Special Instruction(s):

## Premedications

- Acetaminophen (TYLENOL) 650mg PO**, Once, 30 minutes prior to Ocrelizumab infusion.
- Cetirizine (ZYRTEC) 10mg PO**, Once, at least 60 minutes prior to Ocrelizumab infusion.
- Methylprednisolone Sodium Succinate (SOLU-MEDROL) 125mg IVP**, Once, 30 minutes prior to Ocrelizumab infusion.

## Medications

Patient Weight \_\_\_\_\_ kg (**REQUIRED**)

Infuse **Ocrelizumab (OCREVUS)** Intravenously using an infusion set with a 0.2 or 0.22 micron in-line filter

Induction:

- 300mg on Day 1 and Day 15 (two doses, two weeks apart) Infuse at 30mL/hour, increase by 30mL every 30 minutes to a maximum infusion rate of 180mL/hour

Maintenance: (Starting 6 months after Day 1 of Induction)

- 300mg Once, every 6 months
- 600mg Once, every 6 months

Infuse at 40mL/hour, increase by 40mL every 30 minutes to a maximum infusion rate of 200mL/hour

- Meperidine (DEMEROL) 25mg IVP**, Once PRN, for shaking, chills, or rigors. May repeat x1 in 15 minutes if symptoms unresolved.

- IV LINE CARE** per Nursing Policy
- INFUSION REACTION MEDICATIONS** per Standardized Procedures
- TREATMENT ORDER WEIGHT** will be utilized for the duration of the order. Patient will be weighed prior to every treatment. Prescriber will be notified of weight change greater than 10% from baseline weight.

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_ Email \_\_\_\_\_

Printed Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Office Contact \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_