Atrium Health Infusion Centers
**Phone:** 704-468-3400 **Fax:** 704-468-3401

# Ocrevus Infusion Order (Revised 4/3/21)

**Instructions to Provider:** All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

**Required Lab Results**: Hep B Profile, Quant Gold, Hep C Antibody, and CBC with diff prior to first infusion. Notify provider if ALC < 700. Maintenance Doses: Hep B Profile annually and CBC with diff within 90 days of infusion.

**Infusion Therapy:**

☐ Ocrevus (ocrelizumab) 300mg IV days 1 and 15 (Initial)

☐ Ocrevus (ocrelizumab) 600mg IV every 6 months (Maintenance)

**ICD 10 code**: _____

**Pre-Meds: (*Administer 30 minutes prior to Ocrevus*)**

☐ Acetaminophen **1000 mg** PO x 1

☐ Benadryl _____PO or _____ mg IV x 1 *(if applicable, only choose ONE)*

☐ Loratadine **10mg** PO x1

☐ SoluMedrol _____ mg IV x 1

☐ Zofran __**4**____mg IV x 1

**Additional Orders:**

_____

**PRN Meds:**

☒Zofran 4mg IV every 3 hours PRN nausea/vomiting

☒Tylenol 500mg PO every 4 hours PRN pain (give first)

☒Ibuprofen 800mg PO every 8 hours PRN pain (give second)

**Special Instructions:**

- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.
- Initial dose rate: 30ml/hr x 30 minutes, then increase rate by 30ml/hr every 30 minutes, as tolerated, to a max rate of 180ml/hr. (duration: 2.5 hours or longer)
- Initial 600mg dose: 40ml/hr x 30mins, then increase rate by 40ml/hr every 30mins, as tolerated, to a max rate of 200ml/hr (Duration: 3.5hrs or longer)
- Rapid Rate: May transition to rapid rate with 2nd full dose of 600mg if no previous infusion reaction OR following 2 subsequent 600mg doses with no infusion reaction. See PI for rates.
- Infuse using a 0.2 micron in-line filter.

**Infusion Monitoring:**

- Obtain vital signs pre-infusion, 30 minutes after infusion initiation, then every hour for remainder of infusion, and 1 hour after infusion.
- Observe for 1 hour after completion of infusion. Notify provider if patient declines to stay for post-monitoring period.

Provider Name: _____

Provider Signature: _____

Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN:

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