



Atrium Health Infusion Center

Referral Status:	<input type="checkbox"/> New Start <input type="checkbox"/> Order Change <input type="checkbox"/> Renewal
Preferred Location:	<input type="checkbox"/> Atrium Health Infusion Center Concord Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Pineville Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Southpark Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Huntersville Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Kenilworth, a facility of CMC Fax: 704-512-5390 <input type="checkbox"/> Atrium Health Infusion Center Abbey Place, a facility of CMC Fax: 704-512-5390 <input type="checkbox"/> Atrium Health Infusion Center Cabarrus, a facility of CMC Fax: 704-512-5390

Ocrevus® (ocrelizumab) Infusion Order (Revised 10/14/2025)
All orders with a ✓ will be placed.

Patient Demographics:		
Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list) <input type="checkbox"/> NKDA		
Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)		
<input type="checkbox"/> G35.A - Relapsing-Remitting MS	<input type="checkbox"/> G35.B0 - Primary Progressive MS, unspecified	
<input type="checkbox"/> G35.B1 - Active Primary Progressive MS	<input type="checkbox"/> G35.B2 - Non-Active Primary Progressive MS	
<input type="checkbox"/> G35.C1 - Active Secondary Progressive MS	<input type="checkbox"/> Other:	
Required Documentation: (required prior to scheduling)		
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy: <input type="checkbox"/> No Washout Needed	
Copy of Insurance Card (front and back)		
Most Recent Labs (<i>must include labs pertinent to medication ordered</i>)		
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:	
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diagnostic Studies Pertinent to Medication Ordered		
Treatment Parameters:		
Hold treatment and notify provider IF: - Temperature is GREATER THAN 100oF; <input checked="" type="checkbox"/> - Patient complains of symptoms of acute viral or bacterial infection; - Patient is taking an antibiotic for current infection; - Patient presents with signs of PML (Progressive Multifocal Leukoencephalopathy) such as progressive weakness on one side of the body or clumsiness of limbs, disturbance of vision, changes in thinking, memory, and orientation leading to confusion and personality changes.		
Required lab results: - Hep B Profile and IgG PRIOR to FIRST Treatment and then annually; <input checked="" type="checkbox"/> - CBC w/ Diff within 90 days PRIOR to treatment; - LFTs within 90 days PRIOR to treatment; - Serum Creatinine within 90 days PRIOR to treatment.		
Hold treatment and notify provider IF: - Hepatitis B Panel: POSITIVE result or not on file; <input checked="" type="checkbox"/> - ANC LESS THAN 700 or not on file; - LFTs ABNORMAL or not on file; - Serum Creatinine ABNORMAL or not on file.		
Provider Communication:		
<input checked="" type="checkbox"/> Vaccination with live-attenuated or live vaccines is not recommended during treatment with ocrelizumab and after discontinuation, until B-cell repletion. Ensure all immunizations, according to immunization guidelines, are complete at least 4 weeks prior to initiation of ocrelizumab treatment for live or live-attenuated vaccines, and at least 2 weeks prior to initiation of ocrelizumab for non-live vaccines.		
<input checked="" type="checkbox"/> During treatment with ocrelizumab monitor patients for signs and symptoms of PML and immune-mediated colitis. Refer to prescribing information.		
<input checked="" type="checkbox"/> Monitor the levels of quantitative serum immunoglobulins during ocrelizumab treatment and after discontinuation of treatment, until B-cell repletion, especially in the setting of recurrent serious infections. - Consider discontinuing ocrelizumab therapy in patients with serious opportunistic or recurrent serious infections, and if prolonged hypogammaglobulinemia requires treatment with intravenous immunoglobulins.		
Nursing Communication:		
<input checked="" type="checkbox"/> Start PIV/Access CVC and flush device per approved Atrium Health protocol.		
<input checked="" type="checkbox"/> Obtain vital signs PRIOR to treatment, 30 minutes POST initiation of treatment, every 60 minutes for the remainder of treatment, and 60 minutes POST treatment.		
<input checked="" type="checkbox"/> Infuse using a 0.2 micron in-line filter.		
<input checked="" type="checkbox"/> Monitor patient for signs of reaction or side effects for 60 minutes POST-treatment		
Pre-Medications: (Administer all pre-medications 30mins prior to treatment)		
<input type="checkbox"/> Acetaminophen (Tylenol) 1000mg PO ONCE		
<input type="checkbox"/> Diphenhydramine (Benadryl) 25mg PO ONCE		
<input type="checkbox"/> Diphenhydramine (Benadryl) 25mg IV ONCE		
<input type="checkbox"/> Loratadine (Claritin) 10mg PO ONCE		
<input type="checkbox"/> Methylprednisolone sodium succinate (Solu-Medrol) 250mg in sodium chloride 0.9% 100mL IVPB		
<input type="checkbox"/> Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV ONCE		
Infusion Therapy:		
<input type="checkbox"/> Ocrelizumab (Ocrevus) 300mg IV week 0 and week 2		
<input type="checkbox"/> Ocrelizumab (Ocrevus) 600mg IV every 26 weeks		
<input type="checkbox"/> Rapid Ocrelizumab (Ocrevus) Rate: May transition to rapid rate with 2nd full maintenance (600mg) dose, if no previous infusion reaction OR following 2 subsequent 600mg doses with no infusion reaction. See PI for rates.		
Supportive Care Medications:		
<input checked="" type="checkbox"/> Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.		
<input checked="" type="checkbox"/> Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.		
Hypersensitivity Protocol:		
<input checked="" type="checkbox"/> Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.		
Prescriber Information:		
Provider Name:	Phone:	Fax:
Practice Name:	NPI:	
Address:	Office Contact:	
City, State, Zip:	Office Contact Phone Number:	
Physician Signature: (Order expires 12 months from date of signature) No Stamp Signatures Accepted		
Signature:	Date:	