Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Ocrevus Zunovo® (ocrelizumab-hyaluronidase-ocsq) Infusion Order (Revised 11/5/2025)

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)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ G35.A - Relapsing-Remitting MS	☐ G35.B0 - Primary Progressive MS, unspecified
☐ G35.B1 - Active Primary Progressive MS	☐ G35.B2 - Non-Active Primary Progressive MS
☐ G35.C1 - Active Secondary Progressive MS	☐ Other:

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
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.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

☑ Hold treatment and notify provider IF:
- Temperature is GREATER THAN 100oF;
- 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;
- Patient presents with signs of immune-mediated colitis such as new or persistent diarrhea or gastrointestinal signs and symptoms.

☑ Required lab results: (**fax labs with order**)
- Hep B Profile and IgG PRIOR to FIRST Treatment and then annually;
- 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;
- ANC LESS THAN 700 or not on file;
- LFTs ABNORMAL or not on file;
- Serum Creatinine ABNORMAL or not on file.

Provider Communication:

☑ 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 intiation of ocrelizumab for non-live vaccines.

☑ During treatment with ocrelizumab monitor patients for signs and symptoms of PML and immune-mediated colitis. Refer to prescribing information.

☑ 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:

☑ To administer ocrelizumab-hyaluronidase-ocsq (Ocrevus Zunovo):
- Remove the transfer needle from the syringe and replace with a subcutaneous infusion set (e.g., winged/butterfly) containing a 24G-26G needle for injection. Use a subcutaneous infusion set with a priming volume NOT to exceed 0.8mL for administration.
- Prime the subcutaneous line with the drug product solution to eliminate the air in the infusion line and stop before the fluid reaches the needle.
- Ensure the syringe contains exactly 23mL of drug product solution after priming and expelling any excess volume from the syringe.
- Administer immediately to avoid needle clogging. DO NOT store the prepared syringe that has been attached to the already primed subcutaneous infusion set.

☑ Obtain vital signs PRE- and POST- treatment and AS NEEDED for signs/symptoms of reaction during treatment or observation time.

☑ Monitor for signs of reaction during treatment, for at least 60 minutes AFTER 1st treatment, AND for at least 15 minutes AFTER subsequent treatments if first treatment is tolerated well.

☑ Patient Education: Inform patients for CARE AT HOME that infusion reactions can occur within 24hrs after the infusion.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 650mg PO ONCE

☐ Loratadine (Claritin) 10mg PO ONCE

☐ Dexamethasone (Decadron) 20mg PO ONCE

Infusion Therapy:

☑ Ocrelizumab-hyaluronidase-ocsq (Ocrevus Zunovo) 920mg-23,000unit/23mL SC Infusion over 10 minutes every 26 weeks

Supportive Care Medications:

☑ Diphenhydramine-zinc acetate (Benadryl Extra Strength) 2-0.1% cream TOPICAL ONCE PRN localized skin reactions at subcutaneous injection site.

☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6).

☑ Ondansetron (Zofran) 4mg PO ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ 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: