Ascension Rx

Ocrelizumab Hyaluronidase-ocsq (Ocrevus Zunovo & Biosimilars) Infusion Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

☐ Labs to be reviewed or ordered by infusion center

- ☑ Baseline
  - ☑ CBC with Differential
  - ☑ CMP
  - ☑ TB screening (QuantiFERON or alternative)
  - ☑ Hepatitis Screening prior to therapy (HBsAg, HepB core Ab total, HCV)
  - ☐ Serum IgG Levels
- ☑ Maintenance (every _____)
  - ☑ CBC with Differential
  - ☑ CMP
  - ☐ Serum IgG Levels

☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)

☐ Other: _____ ☐

Provider Information

Live vaccines should not be given concurrently

Nursing Orders

☑ Do not administer with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.

☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

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Pre-Medications

- ☐ Acetaminophen 650 mg PO, once
- ☑ Loratadine 10 mg PO, once or Cetirizine 10 mg PO, once (per formulary)
- ☑ Dexamethasone 20 mg PO, once
- ☐ Diphenhydramine 50 mg PO, once
- ☐ Diphenhydramine 25 mg PO, once
- ☐ Other: _____

Medication Orders

☑ Ocrelizumab 920 mg/Hyaluronidase 23,000 units SQ every 6 months for 2 doses

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:
- ☐ Payer-mandated substitution
- ☐ Financial stewardship
- ☐ Patient access / hardship

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Administer in the abdomen using a 24 to 26 gauge winged/butterfly set to be administered over 10 minutes. Use a subcutaneous infusion set with a priming volume not to exceed 0.8mL for administration. Do not administer the remaining priming volume in the subcutaneous infusion set to the patient. (Administration volume = 23 mL).

Monitor patients for 1 hour after the first injection and 15 minutes after each additional injection.

Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
  - ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
  - ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
  - ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
  - ☑ Famotidine 20 mg IV Once PRN hives/itching
  - ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB

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☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated