aleracare
advanced home infusion

HOME INFUSION ONLY

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Ocrevus (ocrelizumab)

Provider Order Form rev. 12/23/2024

Patient Information

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ G35 Multiple Sclerosis ◯ Other: _____

Medication Order

Ocrevus (ocrelizumab) **Dose and Frequency:** ◯ Induction: 300mg IV on day 1 and day 15 Qty: 2 doses

◯ Maintenance: 600mg IV every 6 months (starting 6 months from the first infusion date) Qty: 1 dose

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs (Hep B and Serum Immunolobulins)

◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Pre-Medication Order

Standard Protocol *(give 30 minutes before each infusion)*:

◯ **acetaminophen** (Tylenol) ◯ 1000mg PO ◯ **diphenhydrAMINE** (Benadryl) ◯ 50mg IV

◯ **methylPREDNISolone** (SOLU-Medrol) ◯ 100mg IV ◯ Other: _____

Customized Pre-Medication Order

Drug: _____

Dose: _____ Route: _____ Frequency: _____

Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

◯ RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method

◯ Do NOT administer heparin to this patient

◯ Additional orders: _____

Adverse Reaction and Anaphylaxis Orders

◯ Standard anaphylaxis kit (EPINEPHrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses; Benadryl 50 mg PO PRN for mild-moderate reactions x 1; Benadryl 50 mg IV PRN for mild-moderate reactions x 1)

◯ Additional orders: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

_____

Provider Name **Provider Signature** **Date**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order ◯