Trinity Health Muskegon & Shelby Infusion Clinics
Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444
Shelby: 72 S. State St. Shelby, MI 49455
Fax (shared): 231-672-3970

Ocrelizumab (Ocrevus®)

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies

Order Date: ____/____/____ **Site of Service:** TH Muskegon

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ **Date of Birth**: ____/____/____ **Weight:** _____kg **Height:** _____cm **Allergies:** _____	**Primary Insurance:** _____ **Member ID:** _____ **Secondary Insurance:** _____ **Member ID:** _____
Diagnosis Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	**Labs** No specific labs required. Lab to be ordered at physician discretion. ☐ Other: _____

Date of Negative Hepatitis Screen: _____ **Date of negative Tuberculosis Screen: _____**

Hold/Notify Physician for: signs/symptoms of active infection.

Pre-Medications

- ☒ Diphenhydramine 25 mg IVP 30-60 minutes prior to Ocrelizumab.
- ☒ Acetaminophen 650 mg PO prior to Ocrelizumab
- ☒ Methylprednisolone 100 mg IV Push 30-60 minutes prior to Ocrelizumab
- ☐ Other: _____

℞ Ocrelizumab (Ocrevus®)

☐ **Induction: 300 mg IVPB on day 1 and 15**
☐ **Maintenance: 600 mg IVPB every 6 months (26 weeks), beginning 6 months after the first 300 mg dose**

Nursing Note: Observe patient for 1 hour following completion of each infusion. Administer through a dedicated IV line using a 0.2 or 0.22 micron in-line filter

Nursing Orders:

Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary:

sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN

Provider Name: _____ Provider Signature: _____
Office Phone Number: _____ Office Fax Number: _____
Attending Physician Name: _____
(If ordering provider is an advanced practice practitioner, attending physician required)
Note: This order is valid for 12 months from date of physician signature.