CURBSIDE
INFUSION SERVICES

Patient Name: _____

Date of Birth_____Wt: _____ Ht: _____

Allergies: _____

Ocrevus Physician Order Form

◆ **Orders are initiated unless crossed out by the provider.**

❑ **Check the box to initiate order.**

Please complete this form and fax to (877)-428-1627.

Diagnoses:

❑ Multiple Sclerosis ICD-10: G35

❑ Other_____ ICD-10: _____

❑ No ❑ Yes Hepatitis B virus screening prior to first infusion

❑ No ❑ Yes Quantitative serum immunoglobulins prior to first infusion

Has patient received Ocrevus before ❑ No ❑ Yes date of last infusion: _____

Medication Orders:

Ocrevus ❑ initial dose 300mg i 250ml 0.9% Sodium Chloride on day 1 and 15

❑ maintenance dose: 600 mg in 500 ml 0.9% Sodium Chloride every 6 months

Pre-medications:

❑ Acetaminophen 650 mg - 1000 mg PO prior to infusion and every 6 hours as needed

❑ Antihistamine: Benadryl (or equivalent) 50 mg PO or IV approximately 30 to 60 minutes prior to each Ocrevus infusion and every 6 hours as needed

❑ Methylprednisolone (or equivalent) 100 mg IV approximately 30 minutes before each infusion

❑ Flush line before and after infusion with 5 - 10 ml D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Curbside Infusions protocol.

❑ Infusion Reaction Management per Curbside Infusions protocol as needed.

Nursing Orders

- Infusion Nurse to insert peripheral IV as needed for infusion therapy.
- Monitor VS every 15 minutes the first hour of the infusion and with every rate change.
- Monitor for infusion reactions during the infusions and observe for 1 hour after completion of the infusion.
- Inform patients that infusion reactions can occur up to 24 hours after the infusion.
- Please follow the Ocrevus infusion policy.

_____ _____

Prescriber Signature *Date*

_____

Please Print Name