McLeod Health

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Ocrelizumab (Ocrevus) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis:

☐ G35 Relapsing Remitting Multiple Sclerosis ☐ G35 Primary Progressive Multiple Sclerosis

☐ ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

● Acetaminophen 650 mg PO

● Diphenhydramine: Dose: ☐ 25 mg ☐ 50 mg Route: IVP

● Methylprednisolone: Dose: ☐ 40 mg ☐ 125 mg Route: IVP

☐ Other (include drug, dose, and route): _____

Drug Orders:

● Ocrelizumab (Ocrevus) (J2350) as directed via IV infusion

☐ Induction: 300 mg IV per Sodium Chloride 0.9% 250 mL on Weeks 0 and 2 *(infused at initial rate of 30 mL/hr and increased by 30 mL/hr every 30 minutes up to a max rate of 180 mL/hr)*

☐ Maintenance: 600 mg IV per Sodium Chloride 0.9% 500 mL once every 6 months x 1 dose *(infused at initial rate of 40 mL/hr and increased by 40 mL/hr every 30 minutes up to a max rate of 200 mL/hr; may start at initial rate of 100 mL/hr and increase by 100 mL/hr every 30 minutes up to a max rate of 300 mL/hr if no infusion reactions occur during the first 3 infusions)* *schedule first maintenance dose 24 weeks from Week 0 dose*

• Order Duration: Six months unless otherwise specified (Other: _____)

Lab Orders:

☐ _____

Standing Orders:

● Monitor patient for 1 hour following completion of infusion

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Pre-Screening Requirements:

- Provide Hepatitis screening (Hepatitis B Surface Antigen and Total Hepatitis B Core Antibody) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received ocrelizumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-4655 (Phone)