

McLeod Health

Ocrelizumab (Ocrevus) Treatment Plan

Patient Name: _____ DOB: _____

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

Patient Primary Phone Number: _____

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: Twelve 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.

• Appropriate access and line care orders per health system policy

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 Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

<input type="checkbox"/> McLeod Regional Medical Center (Florence)	<input type="checkbox"/> McLeod Health Loris	<input type="checkbox"/> McLeod Health Cheraw
<input type="checkbox"/> McLeod Health Seacoast (Little River)	<input type="checkbox"/> McLeod Health Dillon	<input type="checkbox"/> McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.