LIFEBRIDGE HEALTH
CARE BRAVELY

OCRELIZUMAB (Ocrevus®)
ORDER FORM

Patient Label

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____ Height: _____

Allergies: _____ Weight: _____

Pre-appointment Documentation:
Please fax most recent office visit note documenting the patient's diagnosis, a copy of the lab results below, as well as a copy of the patient's demographic information along with this order form.

Pre-appointment Lab Results:
The following lab tests must be ordered, completed within 90 days of treatment, and results documented prior to ***initiation*** of ocrelizumab.

- ☐ Quantitative serum immunoglobulins **Date obtained:** _____ **Result:** _____
- ☐ Hepatitis B surface antigen **Date obtained:** _____ **Result:** _____
- ☐ Hepatitis B surface antibody **Date obtained:** _____ **Result:** _____
- ☐ Hepatitis B core IgM **Date obtained:** _____ **Result:** _____

Treatment:

☐ **Premedication(s)** – *please check all premedication(s) desired for treatment*
- ☐ Acetaminophen 650mg PO once
- ☐ Diphenhydramine 50mg PO once
- ☐ Methylprednisolone 100mg IVP once
- ☐ Other: _____

☐ **Ocrelizumab Initiation**

Ocrelizumab Loading Dose – select if patient is being initiated on ocrelizumab *(not for order renewals)*
Day 1 – Ocrelizumab 300mg in 250mL NS IV administered per protocol
Day 15 – Ocrelizumab 300mg in 250mL NS IV administered per protocol

Ocrelizumab Maintenance Dose – begin 6 months from day 1 of loading dose
Ocrelizumab 600mg in 500mL NS IV administered per protocol

☐ **Ocrelizumab Continuation**

Ocrelizumab Maintenance Dose
Ocrelizumab 600mg in 500mL NS IV every 6 months administered per protocol

☒ **Hypersensitivity/Anaphylaxis Medications and Extravasation Management (PRN):** Follow Adult Hypersensitivity Protocol as needed per Nursing Protocol for the treatment of allergic/hypersensitivity reaction. Follow established hospital protocol for extravasation.

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

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410-601-9311
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