 <p>LEGACY HEALTH</p>	<p>Legacy Day Treatment Unit Provider's Orders</p> <p>Adult Ambulatory Infusion Order OCRELIZUMAB (OCREVUS)</p>	<p>Patient Name: _____</p> <p>Date of Birth: _____</p> <p>Med. Rec. No (TVC MRN Only): _____</p>
<p>ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE</p>		

Anticipated Start Date: _____ **Patient to follow up with provider on date:** _____

*****This plan will expire after 365 days, unless otherwise specified below*****

Orders expire: _____

Weight: _____ kg **Height:** _____ cm

Allergies: _____

Diagnosis: _____

Diagnosis Code: _____ (please include primary and secondary diagnosis codes)

Scheduling instructions: Initial dose 300 mg, intravenous, x 2 doses, 14 days apart. Maintenance dose 600 mg, intravenous, starting 6 months after initial dose, every 6 months.

GUIDELINES FOR PRESCRIBING:


1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note.**
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.

PRE-SCREENING: (Results must be available prior to initiation of therapy)

- Hepatitis B surface antigen and core antibody test results scanned with orders.

NURSING ORDERS (TREATMENT PARAMETERS):

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive or if screening has not been performed.
2. RN to assess for active infection. If patient shows signs and symptoms of active infection or currently taking antibiotics. Hold treatment and notify provider
3. VITAL SIGNS – First and second infusions: Obtain vital signs at baseline, then every 30 minutes with rate escalation, then every 30 minutes for the duration of the infusion. Third infusion and beyond: Obtain vital signs at baseline, then every 30 minutes with rate escalation. If no previous infusion reaction, monitor vital signs every hour until infusion complete.
4. Monitor patient for Ocrelizumab infusion-related reactions for 1 hour after completion of first and second Ocrelizumab infusions. Monitoring not required for third infusion and beyond, if no previous infusion reactions. Lengthened monitoring recommended for previous infusion reactions, contact provider for guidance
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, dec clotting (alteplase), and/or dressing changes
6. Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters
7. Nursing communication order, every visit: Monitor patient for potential adverse effects (ADEs) during and after infusion: ADEs may include hypersensitivity reactions and hypotension.
8. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606.
9. Nursing communication orders, every visit: Monitor for signs and symptoms of hypersensitivity during infusion and 30 minutes following completion

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PRE-MEDICATIONS: (Administer 30-60 minutes prior to infusion)

Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit. Give either loratadine or diphenhydrAMINE, not both.
- loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. Give either loratadine or diphenhydrAMINE, not both.
- methylPREDNISolone sodium succinate (SOLU-MEDROL), 100 mg, intravenous, ONCE, every visit
- Other: _____, 30 minutes prior to infusion, every visit
- No routine pre-medications

MEDICATIONS: (must check one)

- Ocrelizumab (OCREVUS) 300 mg in sodium chloride 0.9%, intravenous
Every 2 weeks for 2 treatments


Infuse per infusion plan nursing orders. Infuse through 0.2 micron inline filter. Do not shake

NURSING COMMUNICATION – For 300 mg infusions: Infuse Ocrelizumab via pump slowly at 30 mL/hr for the first half-hour. If no infusion related side effect is seen, increase rate gradually (30 mL/hour) every 30 minutes to a maximum of 180 mL/hour. If infusion not tolerated, STOP infusion, notify provider and administer appropriate hypersensitivity medications. When infusion related side effects have resolved begin the Ocrelizumab infusion at half the previous rate. Resume titrations with provider guidance

- Ocrelizumab (OCREVUS) 600 mg in sodium chloride 0.9%, intravenous
Every 24 weeks, until discontinued

Infuse per infusion plan nursing orders. Infuse through 0.2 micron inline filter. Do not shake

NURSING COMMUNICATION – For 600 mg infusions: If previous infusion reaction, contact provider for rate guidance. If no previous infusion related side effects noted, infuse Ocrelizumab via pump at 100 mL/hr for the first 15 minutes. Increase to 200 mL/hr for the next 15 minutes. Increase to 250 mL/hr for the next 30 minutes. Increase to 300 mL/hr for the remaining 60 minutes. If infusion not tolerated STOP infusion, notify provider and administer appropriate hypersensitivity medications. When infusion related side effects have resolved begin the Ocrelizumab infusion at half the previous rate.

 Legacy Day Treatment Unit Provider's Orders	Adult Ambulatory Infusion Order OCRELIZUMAB (OCREVUS)	Patient Name: Date of Birth: Med. Rec. No (TVC MRN Only):
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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients
2. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for infusion reaction
3. diphenhydramine (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for rash, hypersensitivity or infusion reaction
4. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction
6. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction
7. meperidine (DEMOEROL) injection, 25-50 mg, intravenous, every 2 hours as needed for infusion-related severe rigors in the absence of hypotension. Not to exceed 50 mg/hr
8. sodium chloride 0.9% IV bolus, 1,000 mL, as needed for infusion related side effects

Please check the appropriate box for the patient's preferred clinic location:

- | | |
|---|--|
| <input type="checkbox"/> Legacy Day Treatment Unit –
The Vancouver Clinic Building
<i>A department of Salmon Creek Medical Center</i>
700 NE 87 th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773 | <input type="checkbox"/> Legacy Emanuel Day Treatment Unit
<i>A department of Emanuel Medical Center</i>
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887 |
| <input type="checkbox"/> Legacy Salmon Creek Day Treatment Unit
Legacy Salmon Creek Medical Center
2121 NE 139 th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773 | <input type="checkbox"/> Legacy Silverton STEPS Clinic
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483 |
| <input type="checkbox"/> Legacy Woodburn STEPS Clinic
<i>A department of Silverton Medical Center</i>
Legacy Woodburn Health Center
1475 Mt Hood Ave
Woodburn, OR 97071
Phone number: 503-982-1280
Fax number: 503-225-8723 | |

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Organization/Department: _____