Columbus Community Hospital
Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS
(including Medications)

Ocrelizumab (OCREVUS) Infusion (8/2024) Page 1 of 3

Diagnosis Code: _____

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

This plan will expire after 365 days at which time a new order will need to be placed
** Height, weight, and BSA are required for a complete order**

GUIDELINES FOR ORDERING

1. Send **FACE SHEET** and **H&P or most recent chart 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):

1. Hepatitis B surface antigen and core antibody test results received with orders.

NURSING ORDERS:

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, declotting (alteplase), and/or dressing changes

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.
- ☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE, every visit.
- ☐ methylPREDNISolone sodium succinate (SOLU-MEDROL), 125 mg, intravenous, ONCE, every visit

(cont.)

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PHYSICIANS ORDERS (including Medications)

Ocrelizumab (OCREVUS) Infusion

Monoclonal Antibody:
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.

☐ Ocrelizumab (OCREVUS) 300 mg in 250ml 0.9% NaCl, IV
Induction: 2 doses 14 days apart.
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 500ml 0.9% NaCl, IV
Maintenance dose: every 6 months
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.

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION**.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

(cont.)

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PHYSICIANS ORDERS
(including Medications)

Ocrelizumab (OCREVUS) Infusion

My NPI number is _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

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

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