OCRELIZUMAB (Ocrevus) Infusion Order Form

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine 04976

DIAGNOSIS: ☑ Multiple Sclerosis

Weight: _____kg Height: _____inches [ ] New treatment
[ ] Transfer – Receiving ocrelizumab since_____

LAB:
Screen for Hepatitis B infection: Hep B surface antigen, Hep B Antibody, Hep B Core Antibody total.

PRE-MEDICATE

Required ☑ MethylprednisoLONE IV 100 mg IV

☐ Loratadine 10 mg PO **-or-** ☐ Diphenhydramine PO 25 mg **- or-** _____ mg

-or- ☐Diphenhydramine IV 25 mg **- or-** _____ mg

Optional: ☐ Acetaminophen PO 650 mg **-or-** _____ mg

☐ Ibuprofen PO 400 mg – **or-** _____ mg ☐ Other: _____

INFUSE Ocrelizumab (Ocrevus) – *New order required no less often than every 12 months.*

☐ **New patient** 300 mg IV x 2, 2 weeks apart; then 600 mg IV 6 months later.

☐ **Continuation of treatment:** 600 mg IV every 6 months

NURSING:

1. Supply patient with the manufacturer/FDA Medication Guide.
2. Instruct patient of signs of infusion type reaction and to immediately report headache, difficulty breathing, chest pain or any discomfort. (See infusion guidelines for other types or reactions)
3. Assess for infection; delay administration for active infection.
4. Alteplase 2 mg to restore function of central IV access device, as needed, per RFGH procedure.
5. Vital signs and titration per increase in rate RFGH policy "OCRELIZUMAB INFUSION PROCEDURE"
6. **OTHER:**

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Duration of authorization:_____

Checklist for non-RFGH credentialed providers:
Annually: [ ] H&P completed with last year.

If new therapy:
[ ] Documentation supporting diagnosis and prior therapies
[ ] Hep B screen or document of vaccination
[ ] Problem list, current medication and allergies attached

FAX to RFGH Infusion clinic at 207-858-2404 Contact Infusion Clinic at 207-858-8722

Revised: 8/2025

Provider signature _____Date_____time_____

Printed name_____ Phone # _____

Patient _____

dob_____ phone #_____