OCREVUS® (OCRELIZUMAB) AND OCREVUS ZUNOVO™ (OCRELIZUMAB/HYALURONIDASE) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
Address:		
Phone:	**Height:** ☐ inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
Quantitative Serum IG Levels:	**Hepatitis B Status: Titer date:**_____ ☐ Positive ☐ Negative

Ocrevus® and Ocrevus Zunovo™ Prescription

Ocrevus Initial Dose: ☐ Infuse 300 mg IV over at least 2.5 hours on weeks 0 and 2.

Ocrevus Maintenance Dose: ☐ Infuse 600 mg IV over at least 2 hours every 6 months. Refill as directed x 1 year.
☐ Infuse 600 mg IV over at least 3.5 hours every 6 months. Refill as directed x 1 year.

Ocrevus Zunovo Dose: ☐ Administer 23mL (920 mg ocrelizumab/23,000 units hyaluronidase) subcutaneously in the abdomen via slow push over approximately 10 minutes every 6 months. Refill as directed x 1 year.

☐ Other orders: _____

If planned maintenance dose is missed, administer dose ASAP and reset dosing schedule to six months after the missed dose was administered. Maintenance doses must be separated by at least 5 months.

Ancillary Orders

Anaphylaxis Kit

- Epinephrine 0.3 mg SUBQ or IM x 1 dose & repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25mg IV or IM; may repeat x 1 dose in 15 min PRN if no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

Pre-Medication Orders

- Diphenhydramine 25 mg PO 30 min before infusion.
- Ocrevus IV: Methylprednisolone Sodium Succinate 100 mg IV push over at least 5 minutes approximately 30 min prior to infusion.
- Ocrevus Zunovo: Dexamethasone 20mg PO 30 min before infusion.

☐ Acetaminophen _____mg PO 30 min before infusion. Patient may decline.

☐ Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use.
  For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Quantitative serum IG level (IgG, IgM and IgA) every 6 months to be drawn at maintenance dose infusion visit.

☐Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:		**NPI:**
City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

