ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER	
ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

OCRELIZUMAB (Ocrevus)

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____ Patient Weight: _____ kg Patient Height: _____

DIAGNOSIS & ICD-10 CODE (REQUIRED):

- ❑ Multiple Sclerosis (ICD-10: _____)
- ❑ Other: _____ (ICD-10: _____)

REQUIRED: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

BASELINE LAB REQUIREMENTS:

- ✓ Hepatitis B status (❑ Vaccinated; HepBsAg _____ HepBsAb _____ HepB Core Ab _____)
- ✓ Negative TB Results (Date _____) | ❑ PPD | ❑ QuantiFERON Gold | ❑ Chest X-Ray | ❑ Other: _____

ROUTINE LABS (circle): CMP | CBC w/ diff | LFT | CRP | ESR | ❑ Other: _____

ROUTINE LABS FREQUENCY: ❑ Each Infusion (default) | ❑ Other: _____

IV ACCESS: Access and/or maintain IV or Port-A-Cath per appropriate facility protocol

TREATMENT REGIMEN: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

- ✓ PREMEDICATE (30 minutes prior to infusion):
  - Methylprednisolone 125 mg IV x 1 dose
  - Acetaminophen 650 mg PO x 1 dose
  - Diphenhydramine 25 mg IV x 1 dose (or loratadine 10 mg PO x 1 if cannot tolerate diphenhydramine)
  - Other: _____
- ✓ OCRELIZUMAB IV INFUSION
  - ❑ INITIATION: Ocrelizumab 300 mg IV on Day 1 & 15, then 600 mg every 6 months thereafter
  - ❑ MAINTENTNACE: Ocrelizumab 600 mg every 6 months

ADDITIONAL INFORMATION: _____

MONITORING: 1st & 2nd infusions: vital signs at baseline, at completion of infusion, and before discharge.
Subsequent infusions: vital signs at baseline and at completion of infusion

SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 60 minutes after infusion when vital signs are stable, and no reaction is present. If no infusion-related events with previous 6 infusions, may waive post infusion monitoring and discharge patient home at completion of infusion.

Provider Signature: _____ Date: _____

Print name: _____ Phone # _____ Fax # _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

OCRELIZUMAB (Ocrevus)

MultiCare

Yakima Memorial Hospital