KAISER PERMANENTE®

Name: ______________________________

Kaiser Permanente Member I.D. # ____________

Date of Birth _________________________

Ocrelizumab (OCREVUS)

Infusion Therapy Plan Orders

Instructions to Provider

Review orders and note any changes. All orders with ☑ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers at the end of this protocol).
Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all of the following:

☐ **Pre-Service Authorization** has been obtained by Kaiser Permanente **Fax:** 1-888-282-2685 **Voice**: 1-800-289-1363

Order Date: ___________ **Weight:** ________kg	**Diagnosis:** ICD-10 code *(REQUIRED):* ______________ ICD-10 description______________________________

General Plan Communication

- Anti-CD20 therapies can result in profound hypogammaglobulinemia along with increased infections in a subset of patients. Please obtain baseline immunoglobulins: IgG, IgM, AND IgA prior to initiation of treatment, before each cycle, and every 6 months x 2 after completion of treatment. Please refer to Allergy/Asthma if 1) levels are below normal prior to starting therapy or 2) levels are low and having frequent infections during therapy or 3) levels remain low beyond 9 months post treatment or if 4) IgG is less than 200 at any point.
- Special instructions/notes: ____

Provider Information

- Ensure patient has baseline CBC with differential, Immunoglobulins (IgG, IgM, IgA), Hepatitis B Surface Antigen, Hepatitis B Surface Antibody, Hepatitis B Core Antibody (total), and Hepatitis C screen completed within 3 months prior to treatment start day (first infusion).
- For subsequent infusions (after first two infusions of 300 mg), ensure patient has CBC with differential, Immunoglobulins (IgG, IgM, IgA), and Immunocompetency Panel completed within 1 month, preferably 2 weeks prior to subsequent infusion day.
- If potential pregnancy risk, including female of child-bearing age not using effective contraceptive and sexually active, baseline hCG pregnancy test is completed no earlier than 2 weeks prior to first infusion.
- Do not repeat baseline labs prior to the second dose of ocrelizumab 300 mg if administered 2 weeks following the first infusion (Induction).
- Please choose between two maintenance therapy infusion rates, STANDARD, or ACCELERATED.

Infusion Therapy

Induction Infusion

☑ **ocrelizumab (OCREVUS) in 0.9% sodium chloride 250 mL IV infusion**

Dose: **300 mg**
Route: **Intravenous**
Frequency: **Once on Day 1 and 15**
Infuse over: **Start at 30 mL per hour, increase by 30 mL per hour every 30 minutes. Maximum infusion rate: 180 mL per hour.**
If infusion-related reaction:
1) STOP infusion immediately; 2) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) Notify MD

Medication Guidance: Please choose between two maintenance therapy infusion options, STANDARD, or ACCELERATED.

Provider Signature: ________________________________ **Date:** ____________

Printed Name: ____________________________ **Phone:** ________ **Fax:** ________

Name: ______________________________

Kaiser Permanente Member I.D. # ______________

Date of Birth ______________________________

Ocrelizumab (OCREVUS)
Infusion Therapy Plan Orders

☐ **Maintenance Infusion (STANDARD)**
ocrelizumab (OCREVUS) in 0.9% sodium chloride 500 mL IV infusion
Dose: **600 mg**
Route: **Intravenous**
Frequency: **Once every 6 months**
Infuse over: **Start at 40 mL per hour, increase by 40 mL per hour every 30 minutes. Maximum infusion rate: 200 mL per hour.**
If infusion-related reaction:
2) STOP infusion immediately; 2) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) Notify MD
Note any changes to above regimen: ______________________________

☐ **Maintenance Infusion (ACCELERATED): USE ONLY IF NO SERIOUS REACTION WITH ANY PREVIOUS OCRELIZUMAB INFUSION**
ocrelizumab (OCREVUS) in 0.9% sodium chloride 500 mL IV infusion
Dose: **600 mg**
Route: **Intravenous**
Frequency: **Once every 6 months**
Infuse over: **Start at 100 mL per hour for first 15 minutes, increase to 200 mL per hour for the next 15 minutes, increase to 250 mL per hour for the next 30 minutes, increase to 300 mL per hour for the remaining 60 minutes.**
If infusion-related reaction:
3) STOP infusion immediately; 2) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) Notify MD
Note any changes to above regimen: ______________________________

Pre-Meds

☑ acetaminophen (TYLENOL) tablet
Dose: 650 mg *Route:* Oral *Frequency:* Once, 30 minutes prior to ocrelizumab infusion.
May also be given once as needed during infusion for achiness, headache, or fever.

☑ cetirizine (ZYRTEC) tablet
Dose: 10 mg *Route:* Oral
Frequency: Once, 60 minutes prior to ocrelizumab infusion (if not taken at home)

☑ methylPREDNISolone sodium succinate (SOLU-MEDROL) injectable
Dose: 125 mg *Route:* IV
Frequency: Once, 30 minutes prior to ocrelizumab infusion

☐ Other: ______________________
Dose: _______ *Route:* Oral *Frequency:* Once, 30 minutes prior to ocrelizumab infusion

IV Line Care

☑ 0.9% sodium chloride infusion 250 mL
Rate: 30 mL/hr *Route:* Intravenous *Frequency:* Run continuously to keep vein open
Start peripheral IV if no central line

Infusion Reaction Meds

☑ albuterol (PROVENTIL) nebulizer solution 0.083%
Dose: 2.5 mg *Route:* Nebulization *Frequency:* PRN for shortness of breath/wheezing

☑ diphenhydrAMINE (BENADRYL) injectable
Dose: 25 mg *Route:* Intravenous
Frequency: Once PRN, May repeat x1 for urticaria, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

Provider Signature: ______________________________ **Date:** ______________

Printed Name: ______________________________ **Phone:** ___________ **Fax:** ___________

Name: ____________________

Kaiser Permanente Member I.D. # ____________

Date of Birth ____________________

☑ EPINEPHrine (EpiPen) 0.3mg/0.3mL IM Auto-Injector
Dose: 0.3 mg *Route:* Intramuscular *Frequency:* Once PRN for anaphylaxis. Inject into lateral thigh and hold for 10 seconds. Massage the injected area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5 inch needle for patients with BMI greater than 30. Notify physician if administered.

☑ hydrocortisone sodium succinate (SOLU-CORTEF) injectable
Dose: 100 mg *Route:* Intravenous *Frequency:* Once PRN for hypersensitivity

☑ meperidine (DEMEROL) injectable
Dose: 25 mg *Route:* Intravenous
Frequency: Once PRN, May repeat x1 for shaking chills or rigors. May repeat in 15 minutes if symptoms not resolved.

Nursing Orders

- Contact the prescribing provider prior to the infusion if the patient has evidence of an active infection.
- Contact the provider prior to the infusion if ANC is less than 1,500/mm3 or IgG is less than 500 mg/dL.
- Administer the diluted infusion solution through a dedicated line using an infusion set with a 0.2 or 0.22 micron in-line filter.
- Monitor patient for signs/symptoms of hypersensitivity during infusion and for one hour post-infusion. Complete vital signs one hour post-infusion.
- Discontinue IV line when therapy complete and patient stabilized.

References

OCREVUS® (ocrelizumab) Injection Full Prescribing Information

Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3811 Phone: 425-502-3820

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-3624 Phone: 206-326-3180

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1578 Phone: 425-261-1566

Olympia Medical Center
700 Lilly Road NE, Olympia, WA 98506
Fax: 360-923-7609 Phone: 360-923-7600

Riverfront Medical Center – Spokane
W 322 North River Drive, Spokane, WA 99201
Fax: 509-434-3184 Phone: 509-324-6464

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7421 Phone: 360-307-7410

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-596-3351 Phone: 253-596-3350

Provider Signature: ____________________ **Date:** ____________

Printed Name: ____________________ **Phone:** __________ **Fax:** __________