Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Ocrelizumab-hyaluronidase-ocsq (OCREVUS ZUNOVO) Injection

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Treatment Start Date: _____ Allergies: _____

Weight: _____kg Height: _____cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

1. **FACE SHEET with complete INSURANCE information and patient CONTACT information**
2. **Recent VISIT NOTE to support treatment (if not available in Epic)**
3. **LAB RESULTS for any required prescreening (if not available in Epic)**
4. **DIAGNOSIS CODE _____**
5. **Patient NAME and DATE OF BIRTH on EVERY page faxed**

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.
3. If patient is at high risk for TB exposure, a Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. Please send results with order.

PRE-SCREENING

- ☐ Hepatitis B surface antigen and core antibody test results scanned with orders.
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders if patient is at high risk for TB exposure.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.
- ☐ TB screening is not necessary. Patient is not at high risk for TB exposure.

LABS:

- ☐ CBC with differential, Routine, Clinic Collect, ONCE, every visit
- ☐ Complete metabolic panel, Routine, Clinic Collect, ONCE, every visit

NURSING ORDERS:

1. TREATMENT PARAMETER 1: Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB 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. For first injection, monitor patients for infusion-related reactions during injection and then for 1 hour after completion. For subsequent injections, monitor for 15 minutes after injection is complete. Lengthened monitoring recommended for previous infusion reactions, contact provider for guidance.
4. Do NOT substitute ocrelizumab (for IV administration) and ocrelizumab/hyaluronidase (for SUBQ administration); products have different dosing and are NOT interchangeable.
5. Allow refrigerated product to reach room temperature prior to administration.

6. Vial volume will account for dose volume of 23 mL plus volume needed to prime SUBQ infusion set. Withdraw entire contents of vial into a syringe using a 21-gauge transfer needle, attach an appropriate butterfly infusion set and prime the SUBQ infusion line with the drug product to eliminate air in the infusion line, stopping before the fluid reaches the needle. After priming, ensure the syringe contains exactly 23 mL of drug solution. Solution should be colorless to pale brown and clear to slightly opalescent.
7. Administer immediately to avoid needle clogging. Administer as subcutaneous injection over 10 minutes. Remaining priming volume in infusion tubing does NOT need to be administered.

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

- ☑ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☑ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit. *Give either loratadine or diphenhydrAMINE, not both.*
- ☑ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. *Give either loratadine or diphenhydrAMINE, not both.*
- ☑ dexAMETHasone tablet, 20 mg, oral, ONCE, every visit

MEDICATIONS: ***(must check one)***

- ☑ Ocrelizumab-hyaluronidase-ocsq (OCREVUS ZUNOVO) injection, 920 mg, subcutaneously, ONCE, administer over 10 minutes, every 24 weeks.
  Administer into the abdomen (avoid 2 inches around the navel) subcutaneously over approximately 10 minutes.

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-CKT-133-GUD, Tuality C-132) . Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. DiphenhydrAMINE (BENADRYL) injection, 25–50 mg, intravenous, AS NEEDED X 1 dose for hypersensitivity reaction.
3. EPINEPHrine HCl (ADRENALIN) injection, 0.5 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity reaction.
4. Hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction. Dilute vial by either pressing chamber for Act-O-Vial or diluting powder vial with 2 mL SWFI or NS for injection.
5. Famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose, for hypersensitivity reaction.
6. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for infusion related fever
7. meperidine (DEMEROL) injection, 25-50 mg, intravenous, EVERY 2 HOURS AS NEEDED for infusion-related severe rigors in the absence of hypotension, not to exceed 50 mg/hr.
8. sodium chloride 0.9% IV bolus, 1,000 mL, over 60 minutes, as needed for hypotension (greater than or equal to 20 point change in SBP) or severe reaction

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By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ **License #:** _____ **Date:** _____

Print Name: _____ **Phone:** _____ **Fax**:_____

Plan will expire 1 year after signature date at which time a new order will need to be placed

☑ **Please indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** **Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058**	Phone **(541) 296-7585** Fax **(541) 296-7610**