Lincoln Medical Center

OUTPATIENT INFUSION CENTER

Phone: 931-438-1100
Fax: 1-931-438-1219

Ocrevus Order Set

Patient name: _____ DOB: _____ Sex :( ) Male ( ) Female

SSN:_____ HT: _____ WT: _____ Allergies:_____

Street Address_____ City/State/Zip _____

Home Phone #: _____ Work #: _____ Cell #: _____

Insurance Information:

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Information:

Physician's Name:_____ Referral Contact Name: _____ Phone: _____

Address:_____City/State/Zip_____

DEA#:_____ NPI #:_____ Fax #: _____

State License #: _____

Statement of Medical Necessity

Primary Diagnosis: (ICD-10 Code plus Description)_____

Date of Diagnosis: _____

Access: Does the patient have venous access? ☐Yes ☐ No If Yes, what type? _____

Orders:

*****Normal Saline will be used to clear all lines. All MEDIPORTS/PORTS/VAD will be flushed with Heparin and Saline per hospital protocol. *****

☐ **Do not administer Heparin to this patient.** ☐ **Insert PIV** ☐ **Insert PICC**

1. **Obtain vital signs temperature and patient weight at each appointment**
2. **Screen patient for any infection within the last 14 days or vaccinations within the last 6 weeks**
3. **Lab Orders if needed:** ☐ **CBC** ☐ **BMP** ☐**Other**_____
4. **Start IV and Infuse NS 250ml at KVO and notify Pharmacy**
5. **Start an additional saline lock**
6. **Premedicate Administer 30 minutes before infusion**
   Methylprednisolone 125mg IV once (required)
   Diphenhydramine 50mg IV once (required)
   ☐ **Acetaminophen 650mg PO once**
   ☐ **Other:**_____.
7. **Infuse Ocrelizumab (Ocrevus) and give patient medication guide:**
   Must Use 0.2 Or 0.32 In line Micron Filter
   ☐ **Initial Infusion: 300mg/250ml NS on Day 1 and Day 15**
   Infuse at 30ml/hr X30min
   60ml/hr x30 min
   90ml/hr x30 min

Fax completed form to the Outpatient Infusion Center at 1 (931) 438-1219.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.

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120ml/hr x30 min
150ml/hrx30 min
180 ml/hr Max rate

☐ **Maintenance Infusion: 600mg/500ml NS every 6 months. Begin Maintenance 6 months after the first infusion**

Infuse at 40ml/hr x30min
80ml/hrX30 min
120ml/hr x30 min
160ml/hr x30 min
200ml/hr Max Rate

8. **May Administer:**
   - ☐ **Acetaminophen 1000mg PO PRN headache, mild pain x1 dose**
   - ☐ **Diphenhydramine 25 mg IV PRN chills X1dose**
   - ☐ **Ondansetron 4mg IV PRN nausea X1 dose**
9. **If allergic reaction or infusion related reaction occurs contact MD**
10. **Observe patient for at least one hour after the completion of the infusion**
11. **Special Instructions:**

_____

_____

_____

Physician's Signature _____

Date and Time:_____

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