LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)
For Outpatient Nursing: (541) 271-2171 ext. 5205
FAX: (541) 271-5433

OCRELIZUMAB *(OCREVUS)*

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

INSTRUCTIONS TO PROVIDER:

- *This plan will expire **after 365 days**, at which time new orders will need to be placed.*

MEDICATIONS

Induction

☐ **ocrelizumab** (*OCREVUS)* 300 mg in **sodium chloride 0.9%** IV on **day 1** and **day 15** (for 2 treatments).
Infuse per RN orders. Use a 0.2 or 0.22 micron in-line filter.

Maintenance

☐ **ocrelizumab** (*OCREVUS*) 600 mg in **sodium chloride 0.9%** IV once every 6 months.
Must be separated by at least 5 months - start 6 months after the first 300 mg dose.
Infuse per RN orders. Use a 0.2 or 0.22 micron in-line filter.

ORDERING GUIDELINES

☒ Send FACE SHEET and H&P or most recent chart note

☒ PRIOR to initiating therapy, screen all patients for Hep B virus and high-risk populations for latent infections (hepatitis, tuberculosis).

- Anti-CD20 therapies can result in profound hypogammaglobulinemia along with increased infections in a subset of patients. 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.
- 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.

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Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

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PRE-MEDICATIONS *(Administer 30 to 60 minutes prior to each infusion)*

- ☐ **acetaminophen** 650 mg PO **x** 1
- ☐ **diphenhydrAMINE** *(BENADRYL)* 25 mg PO **x** 1. If cannot tolerate oral, may give IV.
  **Give either loratidine or Benadryl, not both.*
- ☐ **diphenhydrAMINE** *(BENADRYL)* 25 mg IV **x** 1 PRN if cannot tolerate PO.
  **Give either loratidine or Benadryl, not both.*
- ☐ **loratidine** *(CLARITIN)* 10 mg PO **x** 1 PRN if diphenhydramine not given.
  **Give either loratidine or Benadryl, not both.*
- ☐ **methylPREDNISolone sodium succinate** *(SOLU-Medrol)* 40 mg IV **x** 1.
  Administer prior to infusion over 5 minutes.
  Give with each infusion **IF patient has a history of infusion/hypersensitivity reaction*.

TREATMENT PARAMETERS

- ☒ HOLD infusion and CONTACT Provider if patient has temperature **greater than** 100.4°F, complains of symptoms of acute viral or bacterial illness, or if patient is taking antibiotics for current infection.

NURSING ORDERS

- ☒ For first two infusions (300 mg dose): Begin infusion at 30 mL/hour, increase by 30 mL/hour every 30 minutes to a maximum rate of 180 mL/hour. Infusion duration is 2.5 hours or longer
- ☒ For 600 mg dose: Begin infusion at 40 mL/hour, increased by 40 mL/hour every 30 minutes to a maximum rate of 200 mL/hour. Infusion duration is 3.5 hours or longer.
  IF NO previous serious reactions, may begin infusion at 100 mL/hour for first 15 minutes, then increase to 200 mL/hour for next 15 minutes, increase to 250 mL/hour for next 30 minutes, then increase to 300 mL/hour for remaining 60 minutes. Infusion duration is 2 hours or longer.
- ☒ Monitor for infusion reaction during infusion and observe patient for at least 1 hour after infusion is complete.

HYDRATION

- ☒ **sodium chloride 0.9%** *(NORMAL SALINE)* 100 mL at rate of IVPB (flush rate is to the be the same as IVPB infusion rate) PRN IVPB Flush

LINE CARE MAINTENANCE

- ☒ **alteplase** *(CATHFLO ACTIVASE)* 2 mg IVP **x** 1 PRN catheter occlusion.
  ***May repeat x 1 dose after 2 hours** of administration if catheter still occluded*
- ☒ **heparin, porcine** (PF) 100 units/mL IV syringe 500 units intra-catheter **x** 1 PRN line care
- ☒ **sodium chloride 0.9%** flush, 10 mL IV - PRN flush
- ☒ If applicable, may remove PICC line at the completion of course of therapy

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EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:

** *Itching, hives, fever* **

- ☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
- ☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction
- ☒ VS Q15 minutes **x** 4 and PRN
- ☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4HRS PRN Hypersensitivity / Allergic Reaction.
- ☒ **diphenhydramine** *(BENADRYL)* 25 mg IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose
  May repeat **x** 1 ***{Maximum dose = 50 mg}***
- ☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
- ☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

ANAPHYLAXIS REACTION:

** *Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* **

- ☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
- ☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

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