The Lahey Center for Oncology and Hematology
at Parkland Medical Center
Infusion Therapy Services

Ocrelizumab(Ocrevus®) – Adult
Outpatient Use Only

Ocrevus® [package insert] Genentech,Inc.South SanFrancisco CA Mar 2017.

Height:_____(cm) BSA:_____m^2 Weight:_____(Kg)	Allergies:

Diagnosis: Principal ICD-10: _____ Secondary ICD-10:_____

☑ **IV START:** access port or verify central line patency and run 250 mL 0.9% NaCl at rate of 40mL/hr, Lidocaine 1% 0.5 mL intradermal **OR** lidocaine2.5%/prilocaine 2.5% cream prn IV start, 0.9% NaCl flush IV 10mL pre and post infusion, Heparin flush 100 units/mL 5 mL post infusion for VAD

☐ **Treatment for occluded Central Lines: For restoration of function to central VAD as assessed by the ability to withdraw blood.** Alteplase (Cathflo Activase) 2mg per lumen. May repeat x1 after 120 minutes per occlusion incident.
Provider to be notified at time of incident.

Pre-Medication Orders: (Give 30 minutes prior to each Ocrevus® infusion)
Recommended:
☐ Methylprednisolone 100mg in 50ml 0.9% NaCl over 20 minutes
☐ Diphenhydramine _____mg in 50ml 0.9% NaCl over 15 minutes
☐ Diphenhydramine ____mg PO x 1 dose
Others:
☐ Acetaminophen 650mg PO x 1 dose
☐ Famotidine 20mg in 50ml 0.9% NaCl over 20 minutes
☐ Famotidine 20mg PO x1 dose
☐ Loratadine 10mg PO x 1 dose ☐ Other: _____

Medication Order: **Ocrelizumab (Ocrevus®)** *Select Initial **OR** Subsequent Dosing*

INITIAL DOSE: *First dose to be administered as 2 infusions two weeks apart*	**Initial Dose (600mg) administered as two infusions** ☐ **Infusion #1 300mg in 250ml 0.9% NaCl** *followed two weeks later by* **Infusion #2 300mg in 250ml 0.9% NaCl** Start each infusion at a rate of 30ml/hr. Thereafter, increase the rate by 30ml/hr every 30 minutes to a maximum rate of 180ml/hr. Each infusion will last 2.5 hours or longer.
SUBSEQUENT SINGLE INFUSION: *Dosed every 6 months: A new order will be required with each dose.*	**Subsequent infusions** ☐ **Single infusion 600mg in 500ml 0.9% NaCl** Start infusion at a rate of 40ml/hr. Thereafter, increase the rate by 40ml/hr every 30 minutes to a maximum rate of 200ml/hr. Each infusion will last 3.5 hours or longer.

Active observation for infusion-associated reactions in the clinic is recommended during and for <u>at least ONE HOUR</u> after each OCREVUS infusion, or longer at the discretion of the physician.

Medication Order For Infusion Reactions:
☐ Acetaminophen 650 mg PO x 1 dose and every 4 hours as needed for infusion related reactions
☐ Diphenhydramine _____ mg IV push over 2 minutes x 1 dose
☐ Hydrocortisone _____ mg IV push over 1-2 minutes x 1 dose
☐ Famotidine 20mg IV push over 2 minutes x 1 dose
☐ OTHER: _____

Labs: *With each infusion*_____

Monitoring:
☑ Infusion reactions: Management recommendations for infusion reactions depend on the type and severity of the reaction. Permanently discontinue OCREVUS if a life-threatening or disabling infusion reaction occurs
☑ Infection Assessment Prior to every infusion of OCREVUS, determine whether there is an active infection. In case of active infection, delay infusion of OCREVUS until the infection resolves
☑ Vaccination with live-attenuated or live vaccines is not recommended during treatment with OCREVUS and after discontinuation, until B-cell repletion administer all immunizations according to guidelines at least 6 weeks prior to initiation of OCREVUS
☑ Malignancies: An increased risk of malignancy, including breast cancer, may exist with OCREVUS.
☑ Prior to initiating OCREVUS, perform Hepatitis B virus (HBV) screening. OCREVUS is contraindicated in patients with active HBV confirmed by positive results for HBsAg and anti-HBV tests. For patients who are negative for surface antigen [HBsAg] and positive for HB core antibody [HBcAb+] or are carriers of HBV [HBsAg+], consult liver disease experts before starting and during treatment.

Patient Education:
☑ OCREVUS is contraindicated in patients with active HBV infection
☑ OCREVUS infusion reactions may occur up to 24 hours after the infusion.
☑ OCREVUS increased the risk for upper and lower respiratory tract infections, skin infections and herpes-related infections.

_____/_____ _____
Physician Name (Printed) Physician Signature Date/Time

_____/_____ _____
RN Name (Printed) RN Signature Date/Time

Patient Information/Label