ARJ Infusion SERVICES *Specialty Pharmacy & High-Tech Nursing*

FAX completed form to ARJ (877) 451-8955
Intake Specialist (866) 451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Ocrevus Standing Order Form

Patient Information

Patient Name: _____ Date: _____

Physician: _____ Primary Diagnosis: _____

Allergies: _____ DOB: _____ Ht: _____ in / cm Wt : _____ lb / kg

Initiate the following orders: *ARJ policy and protocol to be provided upon request.*

Medication	Maintenance Dosing	Directions	Quantity/Refills
☒ Ocrevus	☒ 600 mg/ 500 mL NS IV every 6 months	☒ Infuse per manufacturer guidelines	Dispense: 1 month supply on all selected medications Refill x12 months unless otherwise noted ☐ *Other:* _____

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure

☐ **Give premedication 30 minutes prior to infusion** *(Note: If nothing is checked, no premeds will be given)*

Diphenhydramine: ☐ 25-50 mg po **OR** ☐ 50 mg IV diluted in D5W or NS 50-100mL, infuse over 10-15 mins.

Antihistamine: ☐ Fexofenadine 180 mg po **OR** ☐ Cetirizine 10 mg po

Methylprednisolone: ☐ 100 mg slow IV push over 5 mins. **OR** ☐ _____ mg slow IV push over 5 mins.

Acetaminophen: ☐ 325-650 mg po **OR** ☐ _____ mg po

☒ RN to monitor vital signs at start of infusion, every 30 minutes and 1 hour post infusion. RN to educate patient on possible side effects, allergic reactions, and when to contact physician.

☒ RN to instruct patient to hydrate pre/post infusion. RN to instruct patient to take Diphenhydramine 25-50 mg po and Acetaminophen 325-650 mg po every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache.

☐ Other: _____

Adverse Reaction Orders: *(Dispense 1 dose of each medication below)*

In the event of an infusion reaction the following orders will be followed and physician will be notified.

For mild reactions such as: itching, flushing, rash – reduce the infusion rate to half the rate at the onset of reaction and maintain reduced rate for at least 30min. If symptoms resolve rate can be increased per manufacturer guidelines. Administer appropriate medication based on symptoms occurring.

For severe reactions such as: bronchospasm, dyspnea – stop infusion and administer appropriate medication based on symptoms occurring. Restart the infusion only after all symptoms have resolved. When restarting, begin at half of the infusion rate at the time of onset of reaction. If this rate is tolerated increase the rate per manufacturer guidelines.

☒ If infusion stopped infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration.

☒ **Diphenhydramine**
50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 minutes or 50 mg/10 mL NS IV push over 2-3 minutes, as tolerated.

☒ **Methylprednisolone**
125 mg (**OR** _____ mg) slow IV push over 5 minutes.

☒ **Acetaminophen**
325-650 mg (**OR** _____ mg) po at onset of symptoms.

☒ **Ondansetron**: 4 mg slow IV push over 5 minutes or 4 mg ODT.

☒ **Epinephrine** pen by weight for use IM or SQ in anaphylactic reaction.
May repeat one time. EMS/911 will be called if used.

☒ **Albuterol inhaler:** 90 mcg/inhalation, 1-2 puffs PRN bronchospasm.

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.
ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

_____ Date: _____
Physician Signature Required - Substitution Permitted

_____ Date: _____
Physician Signature Required - Dispense as Written