MADISON NEUROLOGY LLC

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Neurology Care 7 days a Week. Because Your Brain Matters.

Ocrevus®

Ocrelizumab

COMPLETE CLINICAL PROTOCOL: PRE-TREATMENT CHECKLIST • ORDER SET • FOLLOW-UP • HOLD/DISCONTINUE CRITERIA

GENERIC NAME	ocrelizumab
BRAND	OCREVUS®
MEDICATION CLASS	Anti-CD20 monoclonal antibody (cytolytic)
PRESENTATION	300 mg/10 mL (30 mg/mL) single-dose vial — dilute to 250 mL (300 mg doses) or 500 mL (600 mg doses) in 0.9% sodium chloride
ROUTE	IV infusion only; never IV push or bolus
US INDICATION (FDA)	Relapsing forms of MS (RMS) — clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease — and primary progressive MS (PPMS), in adults.

Class context.
US label covers both relapsing and primary progressive MS — ocrelizumab remains the only DMT with a PPMS indication. Treatment should be initiated and supervised by a physician experienced in neurologic disease, with immediate access to management of severe infusion reactions.

Section 1 — Pre-Treatment Checklist

A. Required screening labs

☐ HBV panel: HBsAg and anti-HBc (total) — REQUIRED before the first dose. HBsAg-positive (active HBV): do NOT start — labeled contraindication. HBsAg-negative/anti-HBc-positive (resolved infection/carrier): consult a liver expert BEFORE starting and monitor for reactivation (clinical signs, LFTs, HBV DNA) during treatment and for at least 1 year after the last dose.

☐ Quantitative serum immunoglobulins (IgG, IgA, IgM) — measure before the first dose; low baseline Ig is a reason to involve immunology before committing. Continue monitoring during treatment and after discontinuation until B-cell repletion if hypogammaglobulinemia develops.

- ☐ CBC with differential and comprehensive metabolic panel — baseline reference for neutropenia and general safety monitoring.
- ☐ Pregnancy test (hCG) for all females of reproductive potential — must be negative before starting; counsel on contraception requirement (see order set).
- ☐ Baseline MRI brain (with and without gadolinium) — reference study for disease activity and indispensable if PML is ever suspected later (distinguishing PML from relapse depends on a good baseline).

B. Vaccinations

- ☐ Live or live-attenuated vaccines: complete ≥4 weeks BEFORE the first infusion (e.g., MMR, varicella, live zoster, yellow fever, intranasal influenza). Do NOT administer during treatment or after discontinuation until B-cell repletion is confirmed.
- ☐ Non-live (inactivated/subunit) vaccines: complete ≥2 weeks BEFORE the first infusion whenever possible; antibody responses are blunted under B-cell depletion, so later vaccination is permissible but less effective.
- ☐ Infants born to mothers treated during pregnancy: do NOT give live vaccines before confirming B-cell recovery (CD19+ count) in the infant; inactivated vaccines per schedule with specialist input.
- ☐ Document influenza/COVID-19 status at each cycle and vaccinate in the window furthest from dosing when feasible (institutional practice).

C. Clinical assessments & counseling

- ☐ Neurologic examination with documented EDSS at baseline.
- ☐ Document relapse history, MRI activity, and all prior DMTs; review the washout/switch interval from the previous agent (lymphocyte-depleting sequences need explicit planning).
- ☐ Medication reconciliation: chronic immunosuppressant co-administration is not recommended (infection additivity); corticosteroid courses for relapses remain appropriate.
- ☐ Screen for active infection by history, examination, and vital signs before EVERY dose — defer if present.
- ☐ Counseling points: infusion reactions (usually first dose; possible up to 24 hours later), infection signs, PML symptoms (progressive weakness, vision change, cognitive change), pregnancy prevention, and the requirement to report intercurrent illness.

D. Exclusion / hold criteria — do not start

CRITERION	RATIONALE / REQUIRED ACTION
Active hepatitis B infection (HBsAg-positive, confirmed)	Labeled contraindication — HBV reactivation under anti-CD20 therapy can be fulminant.
History of life-threatening infusion reaction to ocrelizumab	Labeled contraindication to re-administration.
Active acute or chronic infection	Defer until resolved; immunosuppression amplifies infection risk.
Live vaccine within the past 4 weeks	Defer first dose; vaccine-strain infection risk under impending B-cell depletion.
Significantly low baseline immunoglobulins	Not an absolute bar, but initiate only after immunology risk review.

Section 2 — Order Set

Premedication

- ☐ Methylprednisolone 100 mg IV (or equivalent corticosteroid) approximately 30 minutes before EVERY infusion — mandatory per label.
- ☐ Antihistamine (e.g., diphenhydramine 25–50 mg PO/IV) approximately 30–60 minutes before EVERY infusion — mandatory per label.
- ☐ Antipyretic (e.g., acetaminophen 650 mg PO) approximately 30 minutes before infusion — label: 'may also be considered'; used routinely at most centers.

Dosing schedule

First infusion	300 mg IV (in 250 mL 0.9% NaCl). Start 30 mL/hr; increase by 30 mL/hr every 30 minutes to a maximum 180 mL/hr. Total ~2.5 hours.
Second infusion	300 mg IV 2 weeks after the first, same rate escalation.
Maintenance	600 mg IV (in 500 mL) every 6 months, first maintenance dose 6 months after infusion 1. Start 40 mL/hr; increase by 40 mL/hr every 30 minutes to a maximum 200 mL/hr. Total ~2 hours.
Observation	Monitor closely during the infusion and for at least 1 hour after completion; reactions can occur up to 24 hours post-infusion.
Infusion-reaction management	Mild–moderate: interrupt or reduce rate, restart at HALF the interrupted rate once resolved. Severe: interrupt immediately and treat; life-threatening: permanently discontinue.

Standing orders — every infusion

- ☐ Infection screen (history, exam, vitals) before every infusion — hold if active infection until resolved.
- ☐ Pregnancy test before every infusion for females of reproductive potential.
- ☐ Vital signs at baseline, at each rate change, and at completion; document any infusion reaction and management.
- ☐ Verify premedication administration times before starting the bag.
- ☐ Confirm no live vaccine within 4 weeks / no non-live vaccine within 2 weeks when feasible.

Missed or delayed dose

If a planned dose is missed, administer it as soon as possible — do NOT wait for the next scheduled date. Reset the maintenance interval so the following dose falls 6 months after the administered dose.

Contraception & pregnancy

Females of reproductive potential: effective contraception during treatment and for 6 months after the final dose. IgG crosses the placenta increasingly in the second and third trimesters — infants exposed in utero may be B-cell depleted; defer their live vaccines until CD19+ recovery.

Section 3 — Follow-Up Protocol

ITEM	FREQUENCY / TIMING	ACTION / THRESHOLD
Infection screen (history, exam, vitals)	Before every infusion	Hold dosing for active infection; escalate evaluation for fever ≥38 °C or focal signs.
Quantitative immunoglobulins (IgG/IgA/IgM)	During treatment; after discontinuation until B-cell repletion if low	Declining IgG with recurrent or serious infections → immunology consult; consider extending interval or switching.
CBC with differential	Periodically (at least annually; per institutional protocol each cycle)	Neutropenia: delay dosing until recovered; recurrent grade 3–4 → reassess therapy.
MRI brain	Per disease-monitoring plan (commonly annually); URGENT with any PML-suggestive symptom	New progressive neurologic deficit → MRI with PML protocol before next dose.
HBV reactivation surveillance (resolved-HBV carriers)	Clinical ± HBV DNA per hepatology, during and ≥1 year after treatment	Any reactivation signal → hold and treat per hepatology; do not resume without specialist clearance.

Section 4 — Pause vs. Stop Criteria

A. Pause or delay (resume when resolved)

CRITERION	REQUIRED ACTION
Active infection of any grade	Delay the dose until fully resolved; document resolution before rescheduling.
Live vaccine administered <4 weeks ago	Defer the dose to preserve the vaccine-safety interval.
Significant hypogammaglobulinemia with recurrent infections	Delay next dose pending immunology review of the risk-benefit.
Grade 3 infusion reaction on the current visit	Do not re-challenge the same day; review and plan before rebooking.

B. Discontinue permanently

CRITERION	REQUIRED ACTION
PML — suspected or confirmed	Discontinue permanently; MRI + CSF JCV work-up; manage with neuroinfectious-disease input.
Life-threatening infusion reaction or anaphylaxis	Discontinue permanently (labeled contraindication to further dosing).
HBV reactivation with active hepatitis	Discontinue and treat under hepatology direction.

Pregnancy (elective)	Discuss risks; most centers suspend dosing and resume postpartum — individualized specialist decision.

Section 5 — Notes & Practical Points

- ☐ Anti-CD20 class warning: PML has occurred across the class — any progressive neurologic change that persists for days is an MRI trigger, not a 'watch and wait' item.
- ☐ B-cell depletion persists months beyond the last dose: infection vigilance, live-vaccine prohibition, and blunted vaccine responses all continue until CD19+ repletion.
- ☐ Switching to another high-efficacy DMT after ocrelizumab: document B-cell/immune status first — sequencing rules differ by agent.

Prepared November 2026 by Madison Neurology LLC.

This document is an educational compilation and does not reproduce the complete prescribing information. Verify every element against the current FDA label and applicable REMS requirements before clinical use.

- Current U.S. prescribing information via NIH DailyMed — https://dailymed.nlm.nih.gov/dailymed/
- FDA Drugs@FDA database — https://www.accessdata.fda.gov/scripts/cder/daf/
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Questions about infusion referrals: call 608 403 0000. Neurology Care 7 days a Week. Because Your Brain Matters.