

Please fax both pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to [MyAccredoPatients.com](http://MyAccredoPatients.com) to log in or get started.

Prescription & Enrollment Form  
**Ocrevus® (ocrelizumab)**



Four simple steps to submit your referral.

## 1 Patient Information



Please provide copies of front and back of all medical and prescription insurance cards.

New patient    Current patient

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_

Sex at birth: Male Female Preferred pronouns \_\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_ Date of birth \_\_\_\_\_

Street address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Parent/guardian (if applicable) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Alternate caregiver/contact \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify \_\_\_\_\_

## 2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_

Office/clinic/institution name \_\_\_\_\_

**Prescriber info:** Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_

Prescriber's title \_\_\_\_\_ If NP or PA, under direction of Dr. \_\_\_\_\_

Office phone \_\_\_\_\_ Fax \_\_\_\_\_ NPI # \_\_\_\_\_ License # \_\_\_\_\_

Office contact and title \_\_\_\_\_ Office contact e-mail \_\_\_\_\_

Office street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Infusion location: Patient's home Prescriber's office Infusion site If infusion site, complete information below dotted line:  
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**Infusion info:** Infusion site name \_\_\_\_\_ Clinic/hospital affiliation \_\_\_\_\_

Site street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Infusion site contact \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

**Note: Check the appropriate shipment options in Section 4: Prescribing Information.**

## 3 Clinical Information

**Primary ICD-10 code (REQUIRED):** Multiple Sclerosis: G35 Other \_\_\_\_\_ Laboratory results: LEVF \_\_\_\_\_

Platelets \_\_\_\_\_ Date \_\_\_\_\_ ANC \_\_\_\_\_ Date \_\_\_\_\_

Pregnancy test \_\_\_\_\_ (+/-) Date \_\_\_\_\_ Bilirubin \_\_\_\_\_ Date \_\_\_\_\_

FIRST TWO LOADING DOSES COMPLETED Yes No Note: Ocrevus loading doses must be administered in a controlled setting.

EXPECTED DATE OF FIRST/NEXT INFUSION \_\_\_\_\_

NKDA Known drug allergies \_\_\_\_\_

Concurrent meds \_\_\_\_\_

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_ Date of birth \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_ Phone \_\_\_\_\_

# 4 Prescribing Information

Medication	Dose	Directions	Quantity/Refills	Ship to*:
<b>Loading Doses</b> (two infusions)  Ocrevus® (ocrelizumab)	300mg/10mL SDV Vials are diluted in NS to a final concentration of 1.2mg/mL	<b>Infusion 1:</b> 300mg intravenous in 250mL of 0.9% NS. <b>Infusion 2:</b> (2 weeks later): 300mg intravenous in 250mL of 0.9% NS. Start infusion at 30mL per hour. Increase by 30mL per hour every 30 minutes. Maximum rate: 180mL per hour.  <b>Duration: 2.5 hours or longer</b>	Dispense: 2 vials No refills	<i>Note: Loading doses must be administered in a controlled infusion site.</i> Office Infusion Clinic Unknown
<b>Maintenance Dose</b>  Ocrevus® (ocrelizumab)	300mg/10mL SDV Vials are diluted in NS to a final concentration of 1.2mg/mL	<b>Option 1: Duration: 3.5 hours or longer</b>  Infuse 600mg intravenous in 500mL of 0.9% NS every 6 months (from date of first loading dose). Start infusion at 40mL per hour. Increase by 40mL per hour every 30 minutes. Maximum rate: 200mL per hour.	Dispense: 2 vials Refills 0 1	Home Office Infusion Clinic Unknown
		<b>OR</b>		
		<b>Option 2: Duration: 2 hours or longer</b> <i>Only recommended if no prior serious infusion reaction with any previous Ocrevus infusion.</i>  Infuse 600mg intravenous in 500mL of 0.9% NS every 6 months (from date of first loading dose). Start infusion at 100mL per hour for the first 15 minutes. Increase to 200mL per hour for the next 15 minutes. Increase to 250mL per hour for the next 30 minutes. Increase to 300mL per hour for the remaining 60 minutes.	Dispense: 2 vials Refills 0 1	Home Office Infusion Clinic Unknown

All Ocrevus® orders to be administered via pump and peripheral line unless otherwise instructed.

### Additional Medication and Supplies for Home Infusion

<b>Premedication Orders</b> Acetaminophen 650mg PO 30 min prior to infusion; Diphenhydramine 50mg PO 30 min prior to infusion; Methylprednisolone 100mg IV 30 min prior to infusion  Other _____	Send quantity sufficient for medication infusion  All caregivers and ancillaries to be given per protocol from product package insert. (See next page).
<b>Fluids for Reconstitution and Administration</b> 0.9% NaCl 250mL x2 (initial dose); 0.9% NaCl 500mL (maintenance dose); 0.9% NaCl Flush 10mL (3 mL pre- and post-infusion to maintain peripheral line patency) 0.9% NACL 50mL 0.9% NACL 100mL	If patient requires specific directions on additional medications or supplies, please provide change on the next page and sign.
<b>Hypersensitivity/Anaphylaxis Orders*</b> In the event of anaphylactic reaction, stop infusion of drug immediately. Start NS 15mL/hour; 0.9%NS 100mL. Medicate with epinephrine pen auto-injector 0.3mg/0.3mL IM as needed for anaphylaxis. Call *911*, physician, or paramedic.	
I authorize ancillary supplies or medical equipment necessary such as needles, syringes, etc. to administer the therapy as needed for administration.	
Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. *If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.	

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

**Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS)**

**SIGN HERE**

Date \_\_\_\_\_ Dispense as written \_\_\_\_\_ Date \_\_\_\_\_ Substitution allowed \_\_\_\_\_

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.



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Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_ Date of birth \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_ Phone \_\_\_\_\_

## Accredo Additional Medications for Home Infusion Protocol as Per Package Insert

If your patient requires individualized dosing or administering, please cross out directions below, provide desired directions in the box and sign.

\_\_\_\_\_  
Date Signature

Medication	Dose	Directions
Diphenhydramine IV	50mg/1mL (25mg)	30 minutes prior to infusion, withdraw 0.5ml and inject into 50mL 0.9% NS. Infuse intravenously 101mL/hour over 30 min.
Diphenhydramine IV	50mg/1mL (50mg)	30 minutes prior to infusion, withdraw 1mL and inject into 50mL 0.9% NS. Infuse intravenously 102mL/hour over 30 min.
Methylprednisolone IV	100mg and Diphenhydramine PO	30 min prior to infusion, activate vial, withdraw 1.6mL/100mg, inject into 50mL 0.9% NS. Infuse intravenously 104mL/hour over 30 minutes.
Methylprednisolone IV	100mg and Diphenhydramine IV SIG	Activate vial, withdraw 1.6mL/100mg. Inject 100mg (1.6mL) intravenous push 0.2mL per minute for 8 minutes may increase to 0.4mL per minute for 4 minutes based on absence of infusion reactions (nausea, vomiting, headache, flushing, vital sign change) 30 minutes prior to Ocrevus.
Methylprednisolone IV	125mg SIG	30 minutes prior to infusion, activate vial, withdraw 2mL/125mg, inject into 100mL 0.9% NS. Infuse intravenously 204mL/hour over 30 minutes.
Methylprednisolone IV	250mg SIG	30 minutes prior to infusion, activate vial, withdraw 4mL/250mg, inject into 100mL 0.9% NS. Infuse intravenously 208mL/hour over 30 minutes.
Methylprednisolone IV	500mg SIG	30 min prior to infusion, activate vial, withdraw 8mL/500mg, inject into 100mL 0.9% NS. Infuse intravenously 216mL/hour over 30 minutes.
Methylprednisolone IV	125mg vial and Bacteriostatic water	Reconstitute Methylprednisolone 125mg with 2mL of Bacteriostatic water for injection. Withdraw 1.6mL/100mg. a. Inject 100mg (1.6mL) intravenous push 0.2mL per minute for 8 minutes may increase to 0.4mL per minute for 4 minutes based on absence of infusion reactions (nausea, vomiting, headache, flushing, vital sign change) 30 minutes prior to Ocrevus. b. Withdraw 1.6mL and inject into 50mL 0.9% NS. Infuse intravenously 104mL/hour over 30 minutes. 30 minutes prior to Ocrevus.
Famotidine IV	20mg	30 minutes prior to infusion, withdraw 2mL and inject into 100mL 0.9% NS. Infuse intravenously 204mL/hour over 30 minutes.
Famotidine IV	10mg	30 minutes prior to infusion, withdraw 1mL and inject into 100mL 0.9% NS. Infuse intravenously 202mL/hour over 30 minutes.