Please fax all pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Ocrevus® (ocrelizumab)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

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 _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

Provider will read the following statement: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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 email _____

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:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

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:
☐ Ocrevus Zunovo™ subcutaneous infusion (ocrelizumab and hyaluronidase-ocsq)	920mg ocrelizumab and 23,000 units hyaluronidase per 23mL (40mg and 1,000 units per mL)	☐ Inject 920mg (23mL) subcutaneously into the abdomen over approximately 10 minutes every 6 months **Has patient had at least one prior ocrelizumab infusion in a monitored setting with no serious reaction?** ☐ Yes ☐ No	Dispense: 1 vial Refills ☐ 0 ☐ 1	*First dose to be administered in a monitored setting.* **First Dose:** ☐ Office ☐ Infusion Clinic ☐ Unknown **Subsequent Doses:** ☐ Home ☐ Office ☐ Infusion Clinic ☐ Unknown
☐ Ocrevus® intravenous (ocrelizumab)	300mg/10mL vial diluted in 0.9% NS to a final concentration of 1.2mg/mL	**Loading Doses:** (two infusions) **Duration: 2.5 hours or longer** ☐ Infuse 300mg intravenously in 250mL of 0.9% NS for the first infusion followed by 300mg in 250mL of 0.9% NS 2 weeks later. **Maintenance Doses:** ☐ Infuse 600mg intravenously in 500mL of 0.9% NS every 6 months (from date of first loading dose). **Infuse over:** (Check One) ☐ **3.5 hours or longer** (titrate per package labeling) ☐ **2 hours or longer** (titrate per package labeling) *Only recommended if no prior serious infusion reaction with any previous Ocrevus infusion.*	Dispense: ☐ 2 vials Refills ☐ 0 ☐ 1	*Loading doses to be administered in a monitored setting.* **Loading Doses:** ☐ Office ☐ Infusion Clinic ☐ Unknown **Subsequent Doses:** ☐ Home ☐ Office ☐ Infusion Clinic ☐ Unknown

Additional Medication and Supplies for Home Infusion

If subcutaneous: All Ocrevus Zunovo orders will be administered for subcutaneous injection via pump into the abdomen unless otherwise instructed.
Subcutaneous Administration Method: ☐ Pump ☐ Manual
If Intravenous: All Ocrevus® IV orders to be administered via pump and peripheral line unless otherwise instructed.
Vascular access: ☐ Peripheral access ☐ Central venous
Flushing for Intravenous: NS 0.9% Flush 10mL
If central venous access: Flush with 10mL Sterile NS 0.9% before and after infusion. ☐ Follow with heparin 100units/mL 5mL final flush
If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed

Premedications
Acetaminophen 650mg PO 30 min prior to infusion;
Diphenhydramine 50mg PO 30 min prior to infusion;
Methylprednisolone 100mg IV 30 min prior to infusion
If no IV access - Dexamethasone 20mg PO 30 min prior to infusion

☐ Other _____

Fluids for Reconstitution and Administration (intravenous)
NS 0.9% 500mL (Ocrevus IV maintenance dose);
NS 0.9% 50mL or 100mL (for IV premedications)

☐ Other _____

Hypersensitivity/Anaphylaxis Orders
Start NS 15mL/hour; 0.9% NS 100mL at TKO (IV patients only)
Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis

Send quantity sufficient for medication infusion All caregivers and ancillaries to be given per protocol from product package insert. If patient requires specific directions on additional medications or supplies, please provide change and sign.

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 subcutaneous or IV access as appropriate, 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.