Please fax both 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 _____

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:

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*:
Loading Doses (two infusions) ☐ Ocrevus® (ocrelizumab)	300mg/10mL SDV Vials are diluted in NS to a final concentration of 1.2mg/mL	**Infusion 1:** 300mg intravenous in 250mL of 0.9% NS. **Infusion 2:** (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. **Duration: 2.5 hours or longer**	Dispense: ☐ 2 vials No refills	*Note: Loading doses must be administered in a controlled infusion site.* ☐ Office ☐ Infusion Clinic ☐ Unknown
Maintenance Dose ☐ Ocrevus® (ocrelizumab)	300mg/10mL SDV Vials are diluted in NS to a final concentration of 1.2mg/mL	☐ **Option 1: Duration: 3.5 hours or longer** 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
		OR		
		☐ **Option 2: Duration: 2 hours or longer** *Only recommended if no prior serious infusion reaction with any previous Ocrevus infusion.* 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

Premedication Orders

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 _____

Fluids for Reconstitution and Administration

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

Hypersensitivity/Anaphylaxis Orders*

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.

Send quantity sufficient for medication infusion

All caregivers and ancillaries to be given per protocol from product package insert. (See next page).

If patient requires specific directions on additional medications or supplies, please provide change on the next page and sign.

☐ 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.
Methylprednsiolone 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.
Methylprednsiolone IV	100mg and Diphenydramine 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.
Methylprednsiolone 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.
Methylprednsiolone 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.
Methylprednsiolone 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.

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