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 to log in or get started.

Prescription & Enrollment Form

Ocrevus® (ocrelizumab)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

Patient's first name _____ Last name _____ Middle initial _____

❑ Male ❑ Female 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 _____

Prescriber's first name _____ Last name _____

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

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Infusion clinic name _____ Office/Infusion clinic affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

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

3 Clinical Information

Primary ICD-10 code: _____ Laboratory results: LEVF _____ Date _____

Platelets _____ Date _____ ANC _____ Date _____

Pregnancy test _____ (+/-) Date _____ Bilirubin _____ mg/dL 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

***Provide address for the selected shipment option.**
Check Unknown if assistance is needed to identify infusion site.

Medication	Dose	Directions	Quantity/Refills	Ship to*:
❑ Ocrevus® (ocrelizumab) Initial dose (two infusions) Note: Loading doses must be administered in a controlled infusion site.	300mg/10mL SDV Vials are diluted in NS to a final concentration of 1.2mg/mL	**Infusion 1**: 300mg in 250mL of 0.9% NS. **Infusion 2** (2 weeks later): 300mg in 250mL of 0.9% NS. Start infusion at 30mL per hour. Increase by 30mL per hour every 30 minutes. Maximum: 180mL per hour. Duration: 2.5 hours or longer.	Dispense: ❑ 2 vials No refills	❑ Office ❑ Infusion Clinic ❑ Unknown
❑ Ocrevus® (ocrelizumab) Subsequent doses (one infusion)	300mg/10mL SDV Vials are diluted in NS to a final concentration of 1.2mg/mL	Every 6 months infuse 600mg in 500mL of 0.9% NS. Start infusion at 40mL per hour. Increase by 40mL per hour every 30 minutes. Maximum: 200mL per hour. Duration: 3.5 hours or longer.	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 _____			Send quantity sufficient for medication infusion	
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)				
Hypersensitivity/Anaphylaxis Orders* Stop infusion. Start NS at TKO. 0.9% NaCl 100mL Medicate with: Epinephrine pen Auto-Injector 0.3mg/0.3mL IM as needed for anaphylaxis				
❑ Prescriber, please check here to 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.
By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

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

SIGN HERE PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____

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.

accredo®