

SURNAME: _____ FIRSTNAME(S): _____

DATE OF BIRTH: ____/____/____ MRN: _____



NMDS Multiple Sclerosis Patient Eligibility Form Ocrelizumab (Ocrevus®)

Form must be completed in full and saved securely in the patient's medical record for audit purposes only

TREATMENT	HSE APPROVED INDICATION	ICD10	Protocol Code
Ocrelizumab (Ocrevus®)	Ocrelizumab (Ocrevus®) is indicated for the treatment of adult patients with relapsing forms of multiple sclerosis (RMS) with active disease defined by clinical or imaging features.	G35	MS103a
	OR Ocrelizumab (Ocrevus®) is indicated for the treatment of adult patients with early primary progressive multiple sclerosis (PPMS) in terms of disease duration and level of disability, and with imaging features characteristic of inflammatory activity.	G35	MS103b

ELIGIBILITY		YES	NO
Indication as per protocol MS103a,b			
Eligibility criteria in protocol MS103a,b have been met			
EXCLUSIONS		YES	NO
All contraindications laid out in protocol MS103a,b have been considered.			
PREVIOUS MEDICATION(S) FOR MULTIPLE SCLEROSIS			
Name of Medicine (in order of use; 1. = first line etc.)	Reason for change in treatment (please tick)		
	Adverse Event	Loss of Response	Other Reason
1.			
2.			
3.			
4.			
5.			
PRESCRIBER DETAILS			
Prescriber Name			
Medical Registration Number			
ELIGIBILITY FORM COMPLETED BY			
Name			
Date			