

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER Reg No:** .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

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Fax Number: .....      Fax Number: .....

**Ocrelizumab**

**Initial application — Multiple Sclerosis - ocrelizumab**

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

Diagnosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a neurologist

**and**  Patient has an EDSS score between 0 – 6.0

**and**  Patient has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months

**and**

Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the clinical features were characteristic)

**and**  Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previously experienced symptoms(s)/sign(s)

**and**  Each significant attack has lasted at least one week and has started at least one month after the onset of a previous attack (where relevant)

**and**  Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever (T > 37.5°C)

**and**

Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point

**or**

Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, trigeminal neuralgia, Lhermitte's symptom)

**and**

Evidence of new inflammatory activity on an MRI scan within the past 24 months

**and**

A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion

**or**  A sign of that new inflammatory activity is a lesion showing diffusion restriction

**or**  A sign of that new inflammatory is a T2 lesion with associated local swelling

**or**  A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a recent attack that occurred within the last 2 years

**or**  A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan

**or**

Patient has an active Special Authority approval for either dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizumab or teriflunomide

Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)

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|--|---------------------------|-------------------------------|
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| Reg No: .....                                  | First Names: .....        | First Names: .....            |
| Name: .....                                    | Surname: .....            | Surname: .....                |
| Address: .....                                 | DOB: .....                | Address: .....                |
| .....  | Address: .....            | .....                         |
| .....  | .....                     | .....                         |
| Fax Number: .....                              | .....                     | Fax Number: .....             |

**Ocrelizumab** - *continued*

**Renewal — Multiple Sclerosis - ocrelizumab**

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick box where appropriate)

- Patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use of unilateral or bilateral aids at any time in the last six months (ie the patient has walked 100 metres or more with or without aids in the last six months)

Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

**Initial application — Primary Progressive Multiple Sclerosis**

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- Diagnosis of primary progressive multiple sclerosis (PPMS) meets the 2017 McDonald criteria and has been confirmed by a neurologist
- and
- Patient has an EDSS 2.0 (score equal to or greater than 2 on pyramidal functions) to EDSS 6.5
- and
- Patient has no history of relapsing remitting multiple sclerosis

**Renewal — Primary Progressive Multiple Sclerosis**

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick box where appropriate)

- Patient has had an EDSS score of less than or equal to 6.5 at any time in the last six months (ie patient has walked 20 metres with bilateral assistance/aids, without rest in the last six months)

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)