Please fax both pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.412.4764.

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

Enspryng® (satralizumab-mwge)

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 # _____

Deliver product to patient's home.

3 Clinical Information

Primary ICD-10 code: _____

Diagnosis ❑ G36.0 Neuromyelitis optica Other _____

Is the patient anti-aquaporin-4 antibody positive? ❑ Yes ❑ No ❑ Test pending

Prior NSMOD therapies tried/failed _____

Hep B vaccination: ❑ Yes ❑ No Date _____ Does the patient have active Hepatitis B infection? ❑ Yes ❑ No

Hepatitis B screening: ❑ Hepatitis B surface antigen (HBsAg) results ❑ Positive ❑ Negative Date _____

❑ HB core antibody [HBcAb+] results ❑ Positive ❑ Negative Date _____

Does the patient have active or latent TB infection? ❑ Yes ❑ No Tuberculosis screening: ❑ Positive ❑ Negative Date _____

❑ 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
Enspryng® (satralizumab-mwge)	120mg/mL prefilled syringe	❑ **Treatment naïve:** Inject 120mg subcutaneously at weeks 0, 2 and 4, followed by 120mg every 4 weeks. ❑ **Restart (if 8 to <12 weeks since last dose)** Inject 120mg subcutaneously upon restarting and at 2 weeks, followed by 120mg every 4 weeks. ❑ **Restart (if ≥12 weeks since last dose)** Inject 120mg subcutaneously at weeks 0, 2 and 4, followed by 120mg every 4 weeks.	1-month supply Refills _____ _____

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)** **PHYSICIAN SIGNATURE REQUIRED**

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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