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

Multiple Sclerosis (E–M)

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 # _____

3 Clinical Information

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

Platelets _____ Date _____ ANC _____ Date _____

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

EXPECTED DATE OF FIRST/NEXT INJECTION _____ DATE OF LAST INJECTION (if applicable) _____

Agency nurse to visit home for injection: ❑ Yes ❑ No Agency name & phone _____

❑ 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	Strength/Formulation	Directions	Quantity/Refills
❑ Extavia® (interferon beta-1b)	0.3mg vial	❑ Inject 0.25mg (1mL) subcutaneously every other day. ❑ Dose Titration: • Weeks 1–2: Inject 0.0625mg/0.25mL subcutaneously every other day • Weeks 3–4: Inject 0.125mg/0.50mL subcutaneously every other day • Weeks 5–6: Inject 0.1875mg/0.75mL subcutaneously every other day • Weeks 7+: Inject 0.25mg/ 1mL subcutaneously every other day	❑ 30-day supply (1 kit) ❑ 90-day supply (3 kits) Refills _____
❑ Gilenya® (fingolimod)	0.5mg capsule	Take one 0.5mg capsule by mouth once daily.	❑ 30-day supply #30 ❑ 90-day supply #90 Refills _____
❑ Kesimpta® (ofatumumab)	20mg (0.4mL)	❑ Loading dose: Inject 1 unit (0.4mL) subcutaneously at week 0, 1 and 2. ❑ Maintenance dose: Inject 1 unit (0.4mL) each month.	Supply: ❑ 4-week supply ❑ 12-week supply ❑ Other _____ Refills _____
Lemtrada® (alemtuzumab)	Access Lemtrada® referral form on accredo.com.		
❑ Mavenclad® (cladribine)	10mg tablet	Treatment course: ❑ Year 1 ❑ Year 2 ❑ Take daily by mouth at intervals of 24 hours approximately the same time each day. Check the row corresponding to the patient's weight to prescribe the appropriate number of tablets. Tablets should be taken on consecutive days during each treatment week.	Refills: None

Weight Range (kg)	Number of 10mg tablets per week												
	Week 1						Week 5						
	Day 1	Day 2	Day 3	Day 4	Day 5	Total Tablets Week 1	Day 1	Day 2	Day 3	Day 4	Day 5	Total Tablets Week 5	Total Tablets
❑ 40 to <50	1	1	1	1	0	4	1	1	1	1	0	4	8 (80mg)
❑ 50 to <60	1	1	1	1	1	5	1	1	1	1	1	5	10 (100mg)
❑ 60 to <70	2	1	1	1	1	6	2	1	1	1	1	6	12 (120mg)
❑ 70 to <80	2	2	1	1	1	7	2	2	1	1	1	7	14 (140mg)
❑ 80 to <90	2	2	2	1	1	8	2	2	1	1	1	7	15 (150mg)
❑ 90 to <100	2	2	2	2	1	9	2	2	2	1	1	8	17 (170mg)
❑ 100 to <110	2	2	2	2	2	10	2	2	2	2	1	9	19 (190mg)
❑ 110 and above	2	2	2	2	2	10	2	2	2	2	2	10	20 (200mg)

❑ Other instructions: _____

❑ Other _____ _____			Supply: ❑ 30-day ❑ 90-day ❑ Other _____ Refills _____

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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