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 (M–S)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all 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 phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Date _____

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	Dose	Directions	Quantity/Refills
☐ Mayzent® (siponimod)	☐ 0.25mg starter pack tablet ☐ 1mg tablets ☐ 2mg tablets	☐ Titration for 1mg maintenance dose: Day 1: 1 x 0.25mg Day 3: 2 x 0.25mg Day 2: 1 x 0.25mg Day 4: 3 x 0.25mg ☐ Titration for 2mg maintenance dose: Day 1: 1 x 0.25mg Day 3: 2 x 0.25mg Day 5: 5 x 0.25mg Day 2: 1 x 0.25mg Day 4: 3 x 0.25mg ☐ Maintenance dose of 1mg is 1mg (one 1mg tablet) once daily starting on day 5. ☐ Maintenance dose of 2mg is 2mg (one 2mg tablet) once daily starting on day 6.	Starter Pack: ☐ No refills ☐ 1 refill ☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
Ocrevus® (ocrelizumab)	Access Ocrevus® referral form on **accredo.com**.		
☐ Plegridy® (peginterferon beta-1a) (Subcutaneous injection)	☐ 0.5mL ☐ Autoinjector pen ☐ Prefilled syringe	☐ Inject 125mcg under the skin every 14 days. ☐ Other	Patient is currently receiving a: ☐ 1-month supply ☐ 3-month supply Dispense: ☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Plegridy® (peginterferon beta-1a) (Intramuscular injection)	☐ 0.5mL Prefilled syringe	☐ Inject 125mcg into the muscle every 14 days. ☐ Other	
☐ Rebif® (interferon beta-1a)	☐ Titration Pack (six 8.8mcg and 22mcg PFS) ☐ 22mcg PFS ☐ 44mcg PFS ☐ Titration Pack Rebidose® (six 8.8mcg prefilled autoinjectors and six 22mcg prefilled autoinjectors) ☐ Rebidose® 22mcg prefilled autoinjector ☐ Rebidose® 44mcg prefilled autoinjector	☐ Inject 8.8mcg subcutaneously three time a week weeks 1–2, 22mcg subcutaneously three times a week weeks 3–4, and 44mcg subcutaneously three times a week weeks 5+. ☐ Inject 44mcg subcutaneously three times a week. ☐ Other	☐ 4-week supply (1 kit) ☐ 12-week supply (3 kits) ☐ _____ Refills _____
☐ Other			Supply: ☐ 30-day ☐ 90-day ☐ Other _____ Refills _____

☐ **Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer therapy as needed**

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

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

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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