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 (T–Z)

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
❑ Tecfidera™ (dimethyl fumarate)	❑ Titration Starter Pack (14 capsules of 120mg and 46 capsules of 240mg) ❑ 240mg capsules (#60 per bottle 30 day supply) ❑ 120mg capsules (#14 per bottle 7 day supply)	❑ Titration Starter Pack: take 120mg capsule by mouth twice a day for 7 days followed by 240mg capsule by mouth twice a day. ❑ Maintenance dose: take 240mg capsule by mouth twice a day. ❑ Other _____	❑ Titration Starter Pack: 30-days ❑ Maintenance dose (240mg): Supply: ❑ 30-day ❑ 90-day ❑ Other _____ Refills _____
❑ dimethyl fumarate	❑ Titration Starter Pack (14 capsules of 120mg and 46 capsules of 240mg) ❑ 240mg capsules (#60 per bottle 30 day supply) ❑ 120mg capsules (#14 per bottle 7 day supply)	❑ Titration Starter Pack: take 120mg capsule by mouth twice a day for 7 days followed by 240mg capsule by mouth twice a day. ❑ Maintenance dose: take 240mg capsule by mouth twice a day. ❑ Other _____	❑ Titration Starter Pack: 30-days ❑ Maintenance dose (240mg): Supply: ❑ 30-day ❑ 90-day ❑ Other _____ Refills _____
Tysabri® (natalizumab)	Tysabri® is available only through the TOUCH™ Prescribing Program. Please call 800.456.2255 or go to www.tysabri.com.		
❑ Vumerity™ (diroximel fumarate)	❑ 231mg delayed-release capsules	❑ Starting dose: take 231mg capsule twice a day for 7 days. ❑ Maintenance dose after 7 days: 462mg (administered as two 231mg capsules) twice a day, orally.	Supply: ❑ 30-day ❑ 90-day ❑ Other _____ Refills _____
❑ Zeposia® (ozanimod)	❑ Starter Kit (therapy initiation) (four 0.23mg and three 0.46mg and thirty 0.92mg capsules) ❑ 0.92mg capsule (maintenance) ❑ Starter pack (re-titration only) (four 0.23mg and three 0.46mg capsules)	❑ Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule daily for 3 days, then one 0.92mg capsule daily thereafter. ❑ Take one capsule daily. ❑ Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule daily for 3 days. ❑ Other _____	❑ 4 week supply (1 kit) No refills ❑ 30 capsules = 30-days (1 bottle) Refills _____ ❑ 7-day supply (1 pack) No refills
❑ Other _____ _____			Supply: ❑ 30-day ❑ 90-day ❑ Other _____ Refills _____

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

SIGN HERE

PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____

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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