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Prescription & Enrollment Form Multiple Sclerosis–Interferons

accredo[®]
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

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 _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: Male Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email 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 _____

Office/clinic/institution name _____

Prescriber info: 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 email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: Patient's home Prescriber's office Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Pregnancy test _____ (+/-) 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	Strength/Formulation	Directions	Quantity/Refills
Avonex® (interferon beta-1a)	30mcg prefilled syringe (PFS) 30mcg Avonex Pen (single dose)	Inject 30mcg intramuscularly once a week. Dose Titration: <ul style="list-style-type: none"> • Week 1: Inject 7.5mcg intramuscularly weekly • Week 2: Inject 15mcg intramuscularly weekly • Week 3: Inject 22.5mcg intramuscularly weekly • Week 4+: Inject 30mcg intramuscularly weekly 	4-week supply (1 kit) 12-week supply (3 kits) Refills _____
Betaseron® (interferon beta-1b)	0.3mg vial	Inject 0.25mg (1mL) subcutaneously every other day. Dose Titration: <ul style="list-style-type: none"> • 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 Other _____	28-day supply (1 kit/14 vials) 84-day supply (3 kits/42 vials) Other _____ Refills _____
Extavia® (interferon beta-1b)	0.3mg vial	Inject 0.25mg (1mL) subcutaneously every other day. Dose Titration: <ul style="list-style-type: none"> • 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 _____
Plegridy® (peginterferon beta-1a) (Subcutaneous injection)	0.5mL Autoinjector pen PFS	Titration: Day 1 inject 63mcg under the skin, Day 15 inject 94mcg under the skin, Day 29 inject 125mcg under the skin and repeat every 14 days. 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 _____
Plegridy® (peginterferon beta-1a) (Intramuscular injection)	0.5mL PFS	Titration: Day 1 inject 63mcg into the muscle, Day 15 inject 94mcg into the muscle, Day 29 inject 125mcg into the muscle and repeat every 14 days. Note: see manufacturer form for titration clips prescription for intramuscular injection. Inject 125mcg into the muscle every 14 days. Other _____	Refills _____
Other _____			30-day supply 90-day supply Other _____ Refills _____

Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed. Send quantity sufficient for medication days supply

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.

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
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 times 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) Other _____ Refills _____
Other _____			30-day supply 90-day supply Other _____ Refills _____

Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed. Send quantity sufficient for medication days supply

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.