

Please fax all pages of completed form to your team at 808.650.6487.

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Prescription & Enrollment Form

Multiple Sclerosis–S1P Modulators

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'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 _____

Deliver product to: Prescriber's office Patient's home

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____

To expedite referral processing, please attach the following (as applicable): liver function tests, blood chemistries, complete blood counts, latent infection screenings (Zoster, JC virus, etc), other relevant cardiac and medical history.

Patient weight _____ Date _____ Pregnancy test _____ (+/-) Date _____

Date of last dose (if applicable) _____

ECG completed: Yes Date _____ No Eye exam: Yes Date _____ No

Varicella Zoster status: Prior infection/VZV Ab+ Vaccinated Date completed _____ Unable to confirm immunity

First dose cardiac observation scheduled/completed (date): _____ Not Indicated

CYP2C9 genotype status: _____ 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
Gilenya® (fingolimod) 1st dose observation: Date: _____ Not applicable	0.5mg capsule 0.25mg capsule	[Patients >10 years, weighing >40kg] Take one 0.5mg capsule by mouth once daily. [Patients >10 years, weighing <40kg] Take one 0.25mg capsule by mouth once daily. Date of first dose monitoring: _____ Not applicable	30-day supply #30 90-day supply #90 Refills _____
Mayzent® (siponimod) 1st dose observation: Date: _____ Not applicable	0.25mg starter pack tablet	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	Starter Pack: No refills 1 refill
	1mg tablets 2mg tablets	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.	1-month supply 3-month supply Other _____ Refills _____
Ponvory™ (ponesimod) 1st dose observation: Date: _____ Not applicable	Starter Pack (two 2mg tablets; two 3mg tablets; two 4mg tablets; 5mg tablet; 6mg tablet; 7mg tablet; 8mg tablet; 9mg tablet; three 10mg tablets) Maintenance 20mg tablet	Starting Titration Take dose per schedule below by mouth once daily. Days 1 & 2: take one 2mg tablet Days 3 & 4: take one 3mg tablet Days 5 & 6: take one 4mg tablet Day 7: take one 5mg tablet Day 8: take one 6mg tablet Day 9: take one 7mg tablet Day 10: take one 8mg tablet Day 11: take one 9mg tablet Days 12, 13 & 14: take one 10mg tablet Maintenance Dose Days 15 and after: take one 20mg tablet by mouth once daily.	14-day supply (1 starter pack) No refills 30-day supply (30 tablets, 1 bottle) 90-day supply (90 tablets, 3 bottles) Other _____ 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.

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
Tascenso ODT® (fingolimod) orally disintegrating tablets 1st dose observation: Date: _____ Not applicable	0.5mg orally disintegrating tablet 0.25mg orally disintegrating tablet	[Patients >10 years, weighing >40kg] Dissolve one 0.5mg tablet by mouth once daily. [Patients >10 years, weighing <40kg] Dissolve one 0.25mg tablet by mouth once daily. Date of first dose monitoring: _____ Not applicable	30-day supply #30 90-day supply #90 Refills _____
Zeposia® (ozanimod) 1st dose observation: Date: _____ Not applicable	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, 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.