Please fax all pages of completed form to your team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
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–Self-administered Immunosuppressive

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): ______ Patient wt ______ Date wt obtained ______

To expedite referral processing, please attach the following (as applicable): liver function tests, blood chemistries, complete blood counts, latent infection screenings (HIV, Hep B/C, TB, etc), other relevant cardiac and medical history.

Pregnancy test ______ (+/-) Date ______

Expected date of first/next dose ______ Date of last dose (if applicable) ______

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
Aubagio® (teriflunomide)	7mg tablet 14mg tablet	Take one 7mg tablet by mouth once a day. Take one 14mg tablet by mouth once a day.	30-day supply 90-day supply Other ________ Refills ________
Kesimpta® (ofatumumab)	20mg (0.4mL) prefilled pen	Loading dose: Inject contents of 1 pen subcutaneously at weeks 0, 1 and 2, then maintenance dose of 20mg once monthly beginning at week 4. Maintenance dose: Inject contents of 1 pen subcutaneously (0.4mL) once monthly.	4-week supply 12-week supply Refills ________
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: ____________________________

Ancillary Supplies	
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.

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