Please fax both pages of completed form to your drug therapy 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 (M–S)

accredo®

677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813 5412

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 contact and title ______

Office contact phone number ______ Office contact e-mail ______

Office/clinic/institution name ______ Clinic/hospital affiliation ______

Street address ______ Suite # ______

City ______ State ______ Zip ______

Phone ______ Fax ______ NPI # ______ License # ______

Deliver product to: ❑ Office ❑ Clinic

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
❑ Mayzent® (siponimod)	❑ 0.25mg tablets ❑ 2mg tablets	❑ Titration for 1mg maintenance dose: Day 1: 1 x 0.25mg Day 3: 2 x 0.25mg Day 5: 4 x 0.25mg Day 2: 1 x 0.25mg Day 4: 3 x 0.25mg ❑ Titration for 2mg maintenance dose (starter pack): 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 1mg is 1mg (4 tablets of 0.25mg) once daily starting on day 5. ❑ Maintenance 2mg is 2mg (one 2mg tablet) once daily starting on day 6.	❑ 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 or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.
By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.
Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

PHYSICIAN SIGNATURE REQUIRED

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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