#### Please fax all 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 <u>MyAccredoPatients.com</u> to log in or get started.

### Prescription & Enrollment Form Multiple Sclerosis–Fumarates



Four simple steps to submit your referral.

## **1** Patient Information

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Please provide copies of front and back of all medical and prescription insurance cards.

New patient Current p	atient		
Patient's first name		Last name	Middle initial
Preferred patient first name _		Preferred	patient last name
Sex at birth: Male Fema	ale 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 a	alternate caregiver/contact		
Patient's primary language:	English Other If other, p	ease specify	

## 2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date	Time		Dat	e medication needed		
				_ 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: Pr	escriber's office	Patient's home				

# **3** Clinical Information

 Primary ICD-10 code (REQUIRED):
 Pregnancy test
 (+/-) Date

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

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
Bafiertam™ (monomethyl fumarate)	95mg capsules (#120 per bottle 30-day supply)	Titration: Take one 95mg capsule by mouth twice a day for 7 days followed by two 95mg capsules (190mg) by mouth twice a day thereafter. Maintenance dose: Take two 95mg capsules (190mg) by mouth twice a day. Other	Maintenance dose supply: 30-day supply 90-day supply Other 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 supply (1 kit/30 syr) 90-day supply (3 kits/90 syr) Other Refills
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
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)



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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