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 MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Multiple Sclerosis–Fumarates

accredo®

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): _____ 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)

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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