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–Glatiramer



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 p	atient last name	
Sex at birth: Male Female Gende	r identity	Pronouns	Last 4 digits of SSN	
Date of birth Street ad	ldress		Apt #	
City	St	ate	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 car	egiver/contact			
Patient's primary language: English	Other If other, pleas	e specify		

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date	Fime Date medication needed			
Office/clinic/institution name				
Prescriber's first name	er'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 cor	ntact email	
Office street address			Suite #	
City		_ State	Zip	
Deliver product to: Prescriber's				

3 Clinical Information

Primary ICD-10 code (REQUIRED):		Pregnancy test	(+/-)	Date
NKDA ł	Known drug allergies			
Concurrent m				

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
Copaxone® (glatiramer acetate)	20mg prefilled syringe (PFS)	Inject 20mg subcutaneously daily. Other	30-day supply (1 kit/30 syr) 90-day supply (3 kits/90 syr) Refills
	40mg PFS	Inject 40mg subcutaneously three times a week.	28-day supply (1 kit/12 syr) 84-day supply (3 kits/36 syr) Refills
Glatopa® (glatiramer acetate)	20mg PFS	Inject 20mg subcutaneously daily. Other	30-day supply (1 kit/30 syr) 90-day supply (3 kits/90 syr) Refills
	40mg PFS	Inject 40mg subcutaneously three times a week.	28-day supply (1 kit/12 syr) 84-day supply (3 kits/36 syr) Refills
Other			Supply: 30-day 90-day Other Refills

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 mediation 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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