

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—Self-administered Immunosuppressive



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																																																																																																																																																								
<table border="1"> <thead> <tr> <th rowspan="3">Weight Range (kg)</th> <th colspan="13">Number of 10mg tablets per week</th> <th rowspan="3">Total Tablets</th> </tr> <tr> <th colspan="6">Week 1</th> <th colspan="6">Week 5</th> <th rowspan="2">Total Tablets</th> </tr> <tr> <th>Day 1</th><th>Day 2</th><th>Day 3</th><th>Day 4</th><th>Day 5</th><th>Total Tablets Week 1</th> <th>Day 1</th><th>Day 2</th><th>Day 3</th><th>Day 4</th><th>Day 5</th><th>Total Tablets Week 5</th> </tr> </thead> <tbody> <tr> <td>40 to <50</td><td>1</td><td>1</td><td>1</td><td>1</td><td>0</td><td>4</td><td>1</td><td>1</td><td>1</td><td>1</td><td>0</td><td>4</td><td>8 (80mg)</td> </tr> <tr> <td>50 to <60</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>5</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>5</td><td>10 (100mg)</td> </tr> <tr> <td>60 to <70</td><td>2</td><td>1</td><td>1</td><td>1</td><td>1</td><td>6</td><td>2</td><td>1</td><td>1</td><td>1</td><td>1</td><td>6</td><td>12 (120mg)</td> </tr> <tr> <td>70 to <80</td><td>2</td><td>2</td><td>1</td><td>1</td><td>1</td><td>7</td><td>2</td><td>2</td><td>1</td><td>1</td><td>1</td><td>7</td><td>14 (140mg)</td> </tr> <tr> <td>80 to <90</td><td>2</td><td>2</td><td>2</td><td>1</td><td>1</td><td>8</td><td>2</td><td>2</td><td>1</td><td>1</td><td>1</td><td>7</td><td>15 (150mg)</td> </tr> <tr> <td>90 to <100</td><td>2</td><td>2</td><td>2</td><td>2</td><td>1</td><td>9</td><td>2</td><td>2</td><td>2</td><td>1</td><td>1</td><td>8</td><td>17 (170mg)</td> </tr> <tr> <td>100 to <110</td><td>2</td><td>2</td><td>2</td><td>2</td><td>2</td><td>10</td><td>2</td><td>2</td><td>2</td><td>2</td><td>1</td><td>9</td><td>19 (190mg)</td> </tr> <tr> <td>110 and above</td><td>2</td><td>2</td><td>2</td><td>2</td><td>2</td><td>10</td><td>2</td><td>2</td><td>2</td><td>2</td><td>2</td><td>10</td><td>20 (200mg)</td> </tr> </tbody> </table> <p>Other instructions: _____</p>				Weight Range (kg)	Number of 10mg tablets per week													Total Tablets	Week 1						Week 5						Total Tablets	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	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)
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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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