Prescription & Enrollment Form
Multiple Sclerosis (M–T)

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name ______
Last name ______ Middle initial ______
Date of birth ______ ❑ Male ❑ Female Last 4 digits of SSN ______
Street address ______ Apt # ______
City ______ State ______ Zip ______
Parent/guardian (if applicable) ______
Cell phone ______ Other phone ______
E-mail address ______
Patient's primary language: ❑ English ❑ Other If other, please specify ______

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company ______ Phone ______
Insured's name ______
Insured's employer ______
Relationship to patient ______
Identification # ______
Policy/group # ______
Prescription card: ❑ Yes ❑ No If yes, carrier ______
Policy # ______
Group # ______
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed: ______
Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic
Prescriber's first name ______ Last name ______
Prescriber's title ______
If NP or PA, under direction of Dr. ______
Office contact and title ______
Office contact e-mail ______
Office/clinic/institution name ______
Clinic/hospital location ______
Street address ______ Suite # ______
City ______ State ______ Zip ______
Phone ______ Fax ______
NPI # ______ License # ______

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 ______

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Mayzent® (siponimod)	❑ 0.25 mg tablets ❑ 2 mg tablets	❑ Titration for 1 mg maintenance dose: Day 1: 1 x 0.25 mg Day 2: 1 x 0.25 mg Day 3: 2 x 0.25 mg Day 4: 3 x 0.25 mg Day 5: 4 x 0.25 mg ❑ Titration for 2 mg maintenance dose (mfg provides a starter pack): Day 1: 1 x 0.25 mg Day 2: 1 x 0.25 mg Day 3: 2 x 0.25 mg Day 4: 3 x 0.25 mg Day 5: 5 x 0.25 mg ❑ Maintenance 1 mg is 1 mg (4 tablets of 0.25 mg) once daily starting on day 5. ❑ Maintenance 2 mg is 2 mg (one 2 mg 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)	❑ PEN 63 mcg – 94 mcg starter pack ❑ PEN 125 mcg ❑ PFS 63 mcg – 94 mcg starter pack ❑ PFS 125 mcg	❑ Inject the contents of 1 syringe (125 mcg) under the skin every 14 days. ❑ Dose Titration: Inject 63 mcg under the skin on day 1, then inject 94 mcg under the skin on day 15.	❑ 28-day supply (1 kit/2 syr) ❑ 84-day supply (3 kits/6 syr) Refills ______
❑ Rebif® (interferon beta-1a)	❑ Titration Pack (six 8.8 mcg and 22 mcg PFS) ❑ 22 mcg PFS ❑ 44 mcg PFS ❑ Titration Pack Rebidose® (six 8.8 mcg prefilled autoinjectors and six 22 mcg prefilled autoinjectors) ❑ Rebidose® 22 mcg prefilled autoinjector ❑ Rebidose® 44 mcg prefilled autoinjector	❑ Inject 8.8 mcg subcutaneously three time a week weeks 1–2, 22 mcg subcutaneously three times a week weeks 3–4, and 44 mcg subcutaneously three times a week weeks 5+. ❑ Inject 44 mcg subcutaneously three times a week. ❑ Other: ______	❑ 4-week supply (1 kit) ❑ 12-week supply (3 kits) ❑ ______ Refills ______
❑ Tecfidera™ (dimethyl fumarate)	❑ Titration Starter Pack (14 capsules of 120 mg and 46 capsules of 240 mg) ❑ 240 mg capsules (#60 per bottle 30 day supply) ❑ 120 mg capsules (#14 per bottle 7 day supply)	❑ Titration Starter Pack: take 120 mg capsule by mouth twice a day for 7 days followed by 240 mg capsule by mouth twice a day. ❑ Maintenance dose: take 240 mg capsule by mouth twice a day. ❑ Other: ______	❑ Titration Starter Pack: 30-days ❑ Maintenance dose (240 mg): Supply: ❑ 30-day ❑ 90-day ❑ Other ______ Refills ______
❑ dimethyl fumarate	❑ Titration Starter Pack (14 capsules of 120 mg and 46 capsules of 240 mg) ❑ 240 mg capsules (#60 per bottle 30 day supply) ❑ 120 mg capsules (#14 per bottle 7 day supply)	❑ Titration Starter Pack: take 120 mg capsule by mouth twice a day for 7 days followed by 240 mg capsule by mouth twice a day. ❑ Maintenance dose: take 240 mg capsule by mouth twice a day. ❑ Other: ______	❑ Titration Starter Pack: 30-days ❑ Maintenance dose (240 mg): 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.

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

______ 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.

Please fax completed form to 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.

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