

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
Tysabri® (natalizumab)	Tysabri® is available only through the TOUCH™ Prescribing Program. Please call 800.456.2255 or go to www.tysabri.com.		
<input type="checkbox"/> Vumerity™ (diroximel fumarate)	<input type="checkbox"/> 231 mg delayed-release capsules	<input type="checkbox"/> Starting dose: take 231 mg capsule twice a day for 7 days. <input type="checkbox"/> Maintenance dose after 7 days: 462 mg (administered as two 231 mg capsules) twice a day, orally.	Supply: <input type="checkbox"/> 30-day <input type="checkbox"/> 90-day <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Zeposia® Starter Kit (ozanimod)	<input type="checkbox"/> 4 x 0.23 mg capsule <input type="checkbox"/> 3 x 0.46 mg capsule <input type="checkbox"/> 30 x 0.92 mg capsule	<input type="checkbox"/> Take one 0.23 mg capsule daily for 4 days, then one 0.46 mg capsule for 3 days, then one 0.92 mg capsule daily thereafter. <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 week supply (1 kit) No refills
<input type="checkbox"/> Zeposia® Starter Pack (ozanimod)	<input type="checkbox"/> 4 x 0.23 mg capsule <input type="checkbox"/> 3 x 0.46 mg capsule	<input type="checkbox"/> Take one 0.23 mg capsule daily for 4 days, then one 0.46 mg capsule for 3 days. <input type="checkbox"/> Other: _____	<input type="checkbox"/> 7 day supply (1 pack) No refills
<input type="checkbox"/> Zeposia® (ozanimod)	<input type="checkbox"/> 0.92 mg capsule <input type="checkbox"/> 3 x 0.46 mg capsule	<input type="checkbox"/> Take one capsule daily. <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30 capsules = 30 days (1 bottle) Refills _____
<input type="checkbox"/> Other: _____			Supply: <input type="checkbox"/> 30-day <input type="checkbox"/> 90-day <input type="checkbox"/> 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.