Prescription & Enrollment Form

Multiple Sclerosis (A–F)

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
❑ Aubagio® (teriflunomide)	❑ 7 mg tablet ❑ 14 mg tablet	❑ Take one 7 mg tablet by mouth once a day. ❑ Take one 14 mg tablet by mouth once a day.	❑ 30-day supply ❑ 90-day supply ❑ Other ______ Refills ______
❑ Avonex® (interferon beta-1a)	❑ 30 mcg prefilled syringe (PFS) ❑ 30 mcg Avonex Pen (single dose)	❑ Inject 30 mcg intramuscularly once a week. ❑ Dose Titration: • Week 1: Inject 7.5 mcg intramuscularly weekly • Week 2: Inject 15 mcg intramuscularly weekly • Week 3: Inject 22.5 mcg intramuscularly weekly • Week 4+: Inject 30 mcg intramuscularly weekly	❑ 4-week supply (1 kit) ❑ 12-week supply (3 kits) Refills ______
❑ Betaseron® (interferon beta-1b)	0.3 mg vial	❑ Inject 0.25 mg (1 mL) subcutaneously every other day. ❑ Dose Titration: • Weeks 1–2: Inject 0.0625 mg/0.25 mL subcutaneously every other day • Weeks 3–4: Inject 0.125 mg/0.50 mL subcutaneously every other day • Weeks 5–6: Inject 0.1875 mg/0.75 mL subcutaneously every other day • Weeks 7+: Inject 0.25 mg/1 mL subcutaneously every other day ❑ Other: ______	❑ 28-day supply (1 kit/14 vials) ❑ 84-day supply (3 kits/42 vials) ❑ ______ ______ Refills ______
❑ Copaxone® (glatiramer acetate)	❑ 20 mg PFS	❑ Inject 20 mg subcutaneously daily. ❑ Other: ______	❑ 30-day supply (1 kit/30 syr) ❑ 90-day supply (3 kits/90 syr) Refills ______
	❑ 40 mg PFS	❑ Inject 40 mg subcutaneously three times a week.	❑ 28-day supply (1 kit/12 syr) ❑ 84-day supply (3 kits/36 syr) Refills ______
❑ glatiramer acetate	❑ 20 mg PFS	❑ Inject 20 mg subcutaneously daily. ❑ Other: ______	❑ 30-day supply (1 kit/30 syr) ❑ 90-day supply (3 kits/90 syr) Refills ______
	❑ 40 mg PFS	❑ Inject 40 mg subcutaneously three times a week.	❑ 28-day supply ❑ 84-day supply Refills ______
❑ dalfampridine	10 mg tablet extended-release	Take one tablet every 12 hours.	❑ 30-day supply ❑ 90-day supply Refills ______
❑ Extavia® (interferon beta-1b)	0.3 mg vial	❑ Inject 0.25 mg (1 mL) subcutaneously every other day. ❑ Dose Titration: • Weeks 1–2: Inject 0.0625 mg/0.25 mL subcutaneously every other day • Weeks 3–4: Inject 0.125 mg/0.50 mL subcutaneously every other day • Weeks 5–6: Inject 0.1875 mg/0.75 mL subcutaneously every other day • Weeks 7+: Inject 0.25 mg/ 1 mL subcutaneously every other day	❑ 30-day supply (1 kit) ❑ 90-day supply (3 kits) 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.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. All rights in the product names, trade names or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners. © 2020 Accredo Health Group, Inc. | An Express Scripts Company. All rights reserved. MSS-00008-100120 amc10309 CRP1906_A0294