Please fax both pages of completed form to your drug therapy 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 (M–S)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

Patient's first name _____ Last name _____ Middle initial _____

❑ Male ❑ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ 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 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 _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/clinic/institution name _____ Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Deliver product to: ❑ Office ❑ Clinic

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 _____

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
❑ Mayzent® (siponimod)	❑ 0.25mg tablets ❑ 2mg tablets	❑ Titration for 1mg maintenance dose: Day 1: 1 x 0.25mg Day 3: 2 x 0.25mg Day 5: 4 x 0.25mg Day 2: 1 x 0.25mg Day 4: 3 x 0.25mg ❑ Titration for 2mg maintenance dose (starter pack): Day 1: 1 x 0.25mg Day 3: 2 x 0.25mg Day 5: 5 x 0.25mg Day 2: 1 x 0.25mg Day 4: 3 x 0.25mg ❑ Maintenance 1mg is 1mg (4 tablets of 0.25mg) once daily starting on day 5. ❑ Maintenance 2mg is 2mg (one 2mg 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) (Subcutaneous injection)	❑ 0.5mL ❑ Autoinjector pen ❑ Prefilled syringe	❑ Inject 125mcg under the skin every 14 days. ❑ Other _____ _____	Patient is currently receiving a: ❑ 1-month supply ❑ 3-month supply Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Plegridy® (peginterferon beta-1a) (Intramuscular injection)	❑ 0.5mL Prefilled syringe	❑ Inject 125mcg into the muscle every 14 days. ❑ Other _____ _____	
❑ Rebif® (interferon beta-1a)	❑ Titration Pack (six 8.8mcg and 22mcg PFS) ❑ 22mcg PFS ❑ 44mcg PFS ❑ Titration Pack Rebidose® (six 8.8mcg prefilled autoinjectors and six 22mcg prefilled autoinjectors) ❑ Rebidose® 22mcg prefilled autoinjector ❑ Rebidose® 44mcg prefilled autoinjector	❑ Inject 8.8mcg subcutaneously three time a week weeks 1–2, 22mcg subcutaneously three times a week weeks 3–4, and 44mcg subcutaneously three times a week weeks 5+. ❑ Inject 44mcg subcutaneously three times a week. ❑ Other _____ _____	❑ 4-week supply (1 kit) ❑ 12-week 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 or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.
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)

SIGN HERE 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.

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