

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
<input type="checkbox"/> Mayzent® (siponimod)	<input type="checkbox"/> 0.25mg tablets <input type="checkbox"/> 2mg tablets	<input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> Maintenance 1mg is 1mg (4 tablets of 0.25mg) once daily starting on day 5. <input type="checkbox"/> Maintenance 2mg is 2mg (one 2mg tablet) once daily starting on day 6.	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other Refills _____
Ocrevus® (ocrelizumab)	Access Ocrevus® referral form on acredo.com .		
<input type="checkbox"/> Plegridy® (peginterferon beta-1a) (Subcutaneous injection)	<input type="checkbox"/> 0.5mL <input type="checkbox"/> Autoinjector pen <input type="checkbox"/> Prefilled syringe	<input type="checkbox"/> Inject 125mcg under the skin every 14 days. <input type="checkbox"/> Other _____	Patient is currently receiving a: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other Refills _____
<input type="checkbox"/> Plegridy® (peginterferon beta-1a) (Intramuscular injection)	<input type="checkbox"/> 0.5mL Prefilled syringe	<input type="checkbox"/> Inject 125mcg into the muscle every 14 days. <input type="checkbox"/> Other _____	
<input type="checkbox"/> Rebif® (interferon beta-1a)	<input type="checkbox"/> Titration Pack (six 8.8mcg and 22mcg PFS) <input type="checkbox"/> 22mcg PFS <input type="checkbox"/> 44mcg PFS <input type="checkbox"/> Titration Pack Rebidoze® (six 8.8mcg prefilled autoinjectors and six 22mcg prefilled autoinjectors) <input type="checkbox"/> Rebidoze® 22mcg prefilled autoinjector <input type="checkbox"/> Rebidoze® 44mcg prefilled autoinjector	<input type="checkbox"/> 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+. <input type="checkbox"/> Inject 44mcg subcutaneously three times a week. <input type="checkbox"/> Other _____	<input type="checkbox"/> 4-week supply (1 kit) <input type="checkbox"/> 12-week supply (3 kits) <input type="checkbox"/> _____ 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 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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