

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)

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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 <a href="https://www.accredo.com">accredo.com</a> .		
<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"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<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 Rebidose® (six 8.8mcg prefilled autoinjectors and six 22mcg prefilled autoinjectors) <input type="checkbox"/> Rebidose® 22mcg prefilled autoinjector <input type="checkbox"/> Rebidose® 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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