

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 NoDoes 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.	<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: _____			<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.**