Please fax both pages of completed form to your 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 (A–D)

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 address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Infusion clinic name _____ Office/Infusion clinic affiliation _____

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 _____

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
❑ Aubagio® (teriflunomide)	❑ 7mg tablet ❑ 14mg tablet	❑ Take one 7mg tablet by mouth once a day. ❑ Take one 14mg tablet by mouth once a day.	❑ 30-day supply ❑ 90-day supply ❑ Other _____ Refills _____
❑ Avonex® (interferon beta-1a)	❑ 30mcg prefilled syringe (PFS) ❑ 30mcg Avonex Pen (single dose)	❑ Inject 30mcg intramuscularly once a week. ❑ Dose Titration: • Week 1: Inject 7.5mcg intramuscularly weekly • Week 2: Inject 15mcg intramuscularly weekly • Week 3: Inject 22.5mcg intramuscularly weekly • Week 4+: Inject 30mcg intramuscularly weekly	❑ 4-week supply (1 kit) ❑ 12-week supply (3 kits) Refills _____
❑ Bafiertam™ (monomethyl fumarate)	❑ 95mg capsules (#120 per bottle 30 day supply)	❑ Titration: Take one 95mg capsule by mouth twice a day for 7 days followed by two 95mg capsules (190mg) by mouth twice a day thereafter. ❑ Maintenance dose: Take two 95mg capsules (190mg) by mouth twice a day. ❑ Other _____	❑ Maintenance dose supply: ❑ 30-day supply ❑ 90-day supply ❑ Other _____ Refills _____
❑ Betaseron® (interferon beta-1b)	0.3mg vial	❑ Inject 0.25mg (1mL) subcutaneously every other day. ❑ Dose Titration: • Weeks 1–2: Inject 0.0625mg/0.25mL subcutaneously every other day • Weeks 3–4: Inject 0.125mg/0.50mL subcutaneously every other day • Weeks 5–6: Inject 0.1875mg/0.75mL subcutaneously every other day • Weeks 7+: Inject 0.25mg/1mL subcutaneously every other day ❑ Other _____	❑ 28-day supply (1 kit/14 vials) ❑ 84-day supply (3 kits/42 vials) ❑ _____ _____ Refills _____
❑ Copaxone® (glatiramer acetate)	❑ 20mg PFS	❑ Inject 20mg subcutaneously daily. ❑ Other _____	❑ 30-day supply (1 kit/30 syr) ❑ 90-day supply (3 kits/90 syr) Refills _____
	❑ 40mg PFS	❑ Inject 40mg subcutaneously three times a week.	❑ 28-day supply (1 kit/12 syr) ❑ 84-day supply (3 kits/36 syr) Refills _____
❑ glatiramer acetate	❑ 20mg PFS	❑ Inject 20mg subcutaneously daily. ❑ Other _____	❑ 30-day supply (1 kit/30 syr) ❑ 90-day supply (3 kits/90 syr) Refills _____
	❑ 40mg PFS	❑ Inject 40mg subcutaneously three times a week.	❑ 28-day supply ❑ 84-day supply Refills _____
❑ dalfampridine	10mg tablet extended-release	Take one tablet every 12 hours.	❑ 30-day supply ❑ 90-day supply Refills _____
❑ Other _____ _____			Supply: ❑ 30-day ❑ 90-day ❑ Other _____ Refills _____

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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