

1 PATIENT INFORMATION

Patient name _____
Date of birth _____ Male Female Last 4 digits of SSN _____
Street address _____ Apt# _____
City _____ State _____ Zip _____
Parent/guardian (if applicable) _____
Home phone _____ Work phone _____
Cell phone _____ Evening phone _____
E-mail address _____
Insurance company name _____
Insurance company phone # _____
Insured name _____
Insured employer _____
Relationship to patient _____
Identification # _____ Policy/group # _____
Prescription card No Yes If yes, carrier _____
Policy # _____ Group # _____
Is patient eligible for Medicare? No Yes **Please attach copy of front and back of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____
Prescriber name and title _____
Office contact _____
Clinic / hospital affiliation _____
Street address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____
DEA # _____
Physician Medicaid UPIN # _____
MD specialty _____

To reach the Accredo multiple sclerosis pharmacy, call (toll-free) 1 800 803-2523.

**Please fax completed form to
1 888 302-1028.**

accredo
a medco company

3 CLINICAL INFORMATION

Primary ICD-9 code: _____

Laboratory results:

LEVF _____ Platelets _____ ANC _____
Date _____ Date _____ Date _____
Pregnancy test _____ (+/-) Bilirubin _____ mg/dL
Date _____ 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: _____

- Rx:**
- Avonex® (interferon beta-1a)
 - Betaseron® (interferon beta-1b)
 - Copaxone® (glatiramer acetate)
 - Extavia® (interferon beta-1b)
 - Mitoxantrone HCL
 - Novantrone® (mitoxantrone)
 - Rebif® (interferon beta-1a)

Tysabri® is available only through the TOUCH™ Prescribing Program. Please call 1 800 456-2255 or go to www.tysabri.com.

SIG: Inject dose: _____ mg _____ mg/m2 _____ mcg

Route: SC IM IV Frequency: _____

Dispense quantity: _____ Refills: _____

Supplies (if needed per dose): _____

May dispense 3-month supply

Deliver product to: Office Patient's home Clinic (specify location) _____

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.

Prescriber printed name _____

Prescriber signature (sign below) _____ Date _____

Dispense as written

Substitution allowed

(Physician attests this is his/her legal signature. **NO STAMPS**)