accredo®
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Honolulu, HI 96813-5412

Prescription & Enrollment Form
Enspryng® (satralizumab-mwge)

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current patient

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) _____
Home phone _____
Cell phone _____
Work 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 ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No

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 e-mail _____
Office/clinic/institution name _____
Clinic/hospital affiliation _____
Street address _____ Suite # _____
City _____ State ____ Zip _____
Phone _____
Fax _____
NPI # _____ License # _____
Deliver product to patient's home.

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
Diagnosis
❑ G36.0 Neuromyelitis optica ❑ Other _____
Is the patient anti-aquaporin-4 antibody positive? ❑ Yes ❑ No ❑ Test pending
Prior NSMOD therapies tried/failed _____
Hep B vaccination: ❑ Yes ❑ No Date _____
Does the patient have active Hepatitis B infection? ❑ Yes ❑ No
Hepatitis B screening:
❑ Hepatitis B surface antigen (HBsAg) results ❑ Positive ❑ Negative Date _____
❑ HB core antibody [HBcAb+] results ❑ Positive ❑ Negative Date _____
Does the patient have active or latent TB infection? ❑ Yes ❑ No
Tuberculosis screening: ❑ Positive ❑ Negative Date _____
❑ NKDA ❑ Known drug allergies _____
Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
Enspryng® (satralizumab-mwge)	120 mg/mL prefilled syringe	❑ **Treatment naïve:** Inject 120 mg subcutaneously at weeks 0, 2 and 4, followed by 120 mg every 4 weeks. ❑ **Restart (if 8 to <12 weeks since last dose)** Inject 120 mg subcutaneously upon restarting and at 2 weeks, followed by 120 mg every 4 weeks. ❑ **Restart (if ≥12 weeks since last dose)** Inject 120 mg subcutaneously at weeks 0, 2 and 4, followed by 120 mg every 4 weeks.	1-month supply Refills _____

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, substitution prevention, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions.
Go to MyAccredoPatients.com to log in or get started.