Prescription & Enrollment Form

Multiple Sclerosis (A–D)

accredo®

677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

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 ❑ 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: ______
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
❑ 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, 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 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.

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