

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																																																																																																																																																								
<input type="checkbox"/> Extavia® (interferon beta-1b)	0.3mg vial	<input type="checkbox"/> Inject 0.25mg (1mL) subcutaneously every other day. <input type="checkbox"/> 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	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits) Refills _____																																																																																																																																																								
<input type="checkbox"/> Gilenya® (fingolimod)	0.5mg capsule	Take one 0.5mg capsule by mouth once daily.	<input type="checkbox"/> 30-day supply #30 <input type="checkbox"/> 90-day supply #90 Refills _____																																																																																																																																																								
<input type="checkbox"/> Kesimpta® (ofatumumab)	20mg (0.4mL)	<input type="checkbox"/> Loading dose: Inject 1 unit (0.4mL) subcutaneously at week 0, 1 and 2. <input type="checkbox"/> Maintenance dose: Inject 1 unit (0.4mL) each month.	<input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply <input type="checkbox"/> Other _____ Refills _____																																																																																																																																																								
Lemtrada® (alemtuzumab)	Access Lemtrada® referral form on accredo.com .																																																																																																																																																										
<input type="checkbox"/> Mavenclad® (cladribine)	10mg tablet	Treatment course: <input type="checkbox"/> Year 1 <input type="checkbox"/> Year 2 <input type="checkbox"/> Take daily by mouth at intervals of 24 hours approximately the same time each day. Check the row corresponding to the patient's weight to prescribe the appropriate number of tablets. Tablets should be taken on consecutive days during each treatment week.	Refills: None																																																																																																																																																								
		<table border="1"> <thead> <tr> <th rowspan="3">Weight Range (kg)</th> <th colspan="14">Number of 10mg tablets per week</th> </tr> <tr> <th colspan="6">Week 1</th> <th colspan="6">Week 5</th> <th rowspan="2">Total Tablets</th> </tr> <tr> <th>Day 1</th><th>Day 2</th><th>Day 3</th><th>Day 4</th><th>Day 5</th><th>Total Tablets Week 1</th> <th>Day 1</th><th>Day 2</th><th>Day 3</th><th>Day 4</th><th>Day 5</th><th>Total Tablets Week 5</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> 40 to <50</td> <td>1</td><td>1</td><td>1</td><td>1</td><td>0</td><td>4</td> <td>1</td><td>1</td><td>1</td><td>1</td><td>0</td><td>4</td> <td>8 (80mg)</td> </tr> <tr> <td><input type="checkbox"/> 50 to <60</td> <td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>5</td> <td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>5</td> <td>10 (100mg)</td> </tr> <tr> <td><input type="checkbox"/> 60 to <70</td> <td>2</td><td>1</td><td>1</td><td>1</td><td>1</td><td>6</td> <td>2</td><td>1</td><td>1</td><td>1</td><td>1</td><td>6</td> <td>12 (120mg)</td> </tr> <tr> <td><input type="checkbox"/> 70 to <80</td> <td>2</td><td>2</td><td>1</td><td>1</td><td>1</td><td>7</td> <td>2</td><td>2</td><td>1</td><td>1</td><td>1</td><td>7</td> <td>14 (140mg)</td> </tr> <tr> <td><input type="checkbox"/> 80 to <90</td> <td>2</td><td>2</td><td>2</td><td>1</td><td>1</td><td>8</td> <td>2</td><td>2</td><td>1</td><td>1</td><td>1</td><td>7</td> <td>15 (150mg)</td> </tr> <tr> <td><input type="checkbox"/> 90 to <100</td> <td>2</td><td>2</td><td>2</td><td>2</td><td>1</td><td>9</td> <td>2</td><td>2</td><td>2</td><td>1</td><td>1</td><td>8</td> <td>17 (170mg)</td> </tr> <tr> <td><input type="checkbox"/> 100 to <110</td> <td>2</td><td>2</td><td>2</td><td>2</td><td>2</td><td>10</td> <td>2</td><td>2</td><td>2</td><td>2</td><td>1</td><td>9</td> <td>19 (190mg)</td> </tr> <tr> <td><input type="checkbox"/> 110 and above</td> <td>2</td><td>2</td><td>2</td><td>2</td><td>2</td><td>10</td> <td>2</td><td>2</td><td>2</td><td>2</td><td>2</td><td>10</td> <td>20 (200mg)</td> </tr> </tbody> </table>		Weight Range (kg)	Number of 10mg tablets per week														Week 1						Week 5						Total Tablets	Day 1	Day 2	Day 3	Day 4	Day 5	Total Tablets Week 1	Day 1	Day 2	Day 3	Day 4	Day 5	Total Tablets Week 5	<input type="checkbox"/> 40 to <50	1	1	1	1	0	4	1	1	1	1	0	4	8 (80mg)	<input type="checkbox"/> 50 to <60	1	1	1	1	1	5	1	1	1	1	1	5	10 (100mg)	<input type="checkbox"/> 60 to <70	2	1	1	1	1	6	2	1	1	1	1	6	12 (120mg)	<input type="checkbox"/> 70 to <80	2	2	1	1	1	7	2	2	1	1	1	7	14 (140mg)	<input type="checkbox"/> 80 to <90	2	2	2	1	1	8	2	2	1	1	1	7	15 (150mg)	<input type="checkbox"/> 90 to <100	2	2	2	2	1	9	2	2	2	1	1	8	17 (170mg)	<input type="checkbox"/> 100 to <110	2	2	2	2	2	10	2	2	2	2	1	9	19 (190mg)	<input type="checkbox"/> 110 and above	2	2	2	2	2	10	2	2	2	2	2	10	20 (200mg)
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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.