Prescription & Enrollment Form

Multiple Sclerosis (T–Z)

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
Tysabri® (natalizumab)	Tysabri® is available only through the TOUCH™ Prescribing Program. Please call 800.456.2255 or go to www.tysabri.com.		
❑ Vumerity™ (diroximel fumarate)	❑ 231mg delayed-release capsules	❑ Starting dose: take 231mg capsule twice a day for 7 days. ❑ Maintenance dose after 7 days: 462mg (administered as two 231mg capsules) twice a day, orally.	Supply: ❑ 30-day ❑ 90-day ❑ Other _____ Refills _____
❑ Zeposia® (ozanimod)	❑ Starter Kit (therapy initiation) (four 0.23mg and three 0.46mg and thirty 0.92mg capsules)	❑ Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule daily for 3 days, then one 0.92mg capsule daily thereafter.	❑ 4 week supply (1 kit) No refills
	❑ 0.92mg capsule (maintenance)	❑ Take one capsule daily.	❑ 30 capsules = 30-days (1 bottle) Refills _____
	❑ Starter pack (re-titration only) (four 0.23mg and three 0.46mg capsules)	❑ Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule daily for 3 days. ❑ Other: _____	❑ 7-day supply (1 pack) No 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.