

Please fax all pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to [MyAccredoPatients.com](https://MyAccredoPatients.com) to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

# Multiple Sclerosis–Fumarates

**EVERNORTH**  
HEALTH SERVICES

Four simple steps to submit your referral.

## 1 Patient Information



Please provide copies of front and back of all medical and prescription insurance cards.

New patient      Current patient

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_

Preferred patient first name \_\_\_\_\_ Preferred patient last name \_\_\_\_\_

Sex at birth:    Male    Female    Gender identity \_\_\_\_\_ Pronouns \_\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_

Date of birth \_\_\_\_\_ Street address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Parent/guardian (if applicable) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Alternate caregiver/contact \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

OK to leave message with alternate caregiver/contact

Patient's primary language:    English    Other    If other, please specify \_\_\_\_\_

**Provider will read the following statement to patient:** By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

## 2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_

Office/clinic/institution name \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_

Prescriber's title \_\_\_\_\_ If NP or PA, under direction of Dr. \_\_\_\_\_

Office phone \_\_\_\_\_ Fax \_\_\_\_\_ NPI # \_\_\_\_\_ License # \_\_\_\_\_

Office contact and title \_\_\_\_\_ Office contact email \_\_\_\_\_

Office street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Deliver product to:    Prescriber's office    Patient's home

## 3 Clinical Information

**Primary ICD-10 code (REQUIRED):** \_\_\_\_\_ Pregnancy test \_\_\_\_\_ (+/-) Date \_\_\_\_\_

To expedite referral processing, please attach the following (as applicable): liver function tests, blood chemistries, complete blood counts, latent infection screenings (Zoster, TB, JC virus, etc), other relevant medical history.

NKDA    Known drug allergies \_\_\_\_\_

Concurrent meds \_\_\_\_\_

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_ Date of birth \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_ Phone \_\_\_\_\_

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Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/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 _____
Tecfidera® (dimethyl fumarate)	Titration Starter Pack (14 capsules of 120mg and 46 capsules of 240mg) 240mg capsules (#60 per bottle 30-day supply) 120mg capsules (#14 per bottle 7-day supply)	Titration Starter Pack: Take 120mg capsule by mouth twice a day for 7 days followed by 240mg capsule by mouth twice a day. Maintenance dose: Take 240mg capsule by mouth twice a day. Other _____	Titration Starter Pack: 30 days Maintenance dose (240mg) supply: 30-day supply (1 kit/30 syr) 90-day supply (3 kits/90 syr) Other _____ Refills _____
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 _____
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.

Prescriber's signature required (sign below)    (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

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.