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 to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Multiple Sclerosis–Interferons

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 info: 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 _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Pregnancy test _____ (+/-) Date _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/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 _____
☐ 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) ☐ Other _____ Refills _____
☐ Plegridy® (peginterferon beta-1a) (Subcutaneous injection)	0.5mL ☐ Autoinjector pen ☐ PFS	☐ Titration: Day 1 inject 63mcg under the skin, Day 15 inject 94mcg under the skin, Day 29 inject 125mcg under the skin and repeat every 14 days. ☐ Inject 125mcg under the skin every 14 days. ☐ Other _____	Patient is currently receiving a: ☐ 1-month supply ☐ 3-month supply Dispense: ☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Plegridy® (peginterferon beta-1a) (Intramuscular injection)	0.5mL PFS	☐ Titration: Day 1 inject 63mcg into the muscle, Day 15 inject 94mcg into the muscle, Day 29 inject 125mcg into the muscle and repeat every 14 days. **Note: see manufacturer form for titration clips prescription for intramuscular injection.** ☐ Inject 125mcg into the muscle every 14 days. ☐ Other _____	
☐ Other _____			☐ 30-day supply ☐ 90-day supply ☐ Other _____ Refills _____

Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed. Send quantity sufficient for medication days supply

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.

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
☐ Rebif® (interferon beta-1a)	☐ Titration Pack (six 8.8mcg and 22mcg PFS) ☐ 22mcg PFS ☐ 44mcg PFS ☐ Titration Pack Rebidose® (six 8.8mcg prefilled autoinjectors and six 22mcg prefilled autoinjectors) ☐ Rebidose® 22mcg prefilled autoinjector ☐ Rebidose® 44mcg prefilled autoinjector	☐ Inject 8.8mcg subcutaneously three times a week weeks 1–2, 22mcg subcutaneously three times a week weeks 3–4, and 44mcg subcutaneously three times a week weeks 5+. ☐ Inject 44mcg subcutaneously three times a week. ☐ Other _____	☐ 4-week supply (1 kit) ☐ 12-week supply (3 kits) ☐ Other _____ Refills _____
☐ Other _____			☐ 30-day supply ☐ 90-day supply ☐ Other _____ Refills _____

Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed. Send quantity sufficient for medication days supply

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.

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