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–S1P Modulators

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): _____

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

Patient weight _____ Date _____ Pregnancy test _____ (+/-) Date _____

Date of last dose (if applicable) _____

ECG completed: ☐ Yes Date _____ ☐ No Eye exam: ☐ Yes Date _____ ☐ No

Varicella Zoster status: ☐ Prior infection/VZV Ab+ ☐ Vaccinated Date completed _____ ☐ Unable to confirm immunity

First dose cardiac observation scheduled/completed (date): _____ ☐ Not Indicated

CYP2C9 genotype status: _____ 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
☐ Gilenya® (fingolimod) 1st dose observation: Date: _____ ☐ Not applicable	☐ 0.5mg capsule ☐ 0.25mg capsule	☐ [Patients >10 years, weighing >40kg] Take one 0.5mg capsule by mouth once daily. ☐ [Patients >10 years, weighing <40kg] Take one 0.25mg capsule by mouth once daily. Date of first dose monitoring: _____ ☐ Not applicable	☐ 30-day supply #30 ☐ 90-day supply #90 Refills _____
☐ Mayzent® (siponimod) 1st dose observation: Date: _____ ☐ Not applicable	☐ 0.25mg starter pack tablet	☐ Titration for 1mg maintenance dose: Day 1: 1 x 0.25mg Day 3: 2 x 0.25mg Day 2: 1 x 0.25mg Day 4: 3 x 0.25mg ☐ Titration for 2mg maintenance dose: Day 1: 1 x 0.25mg Day 3: 2 x 0.25mg Day 5: 5 x 0.25mg Day 2: 1 x 0.25mg Day 4: 3 x 0.25mg	Starter Pack: ☐ No refills ☐ 1 refill
	☐ 1mg tablets ☐ 2mg tablets	☐ Maintenance dose of 1mg is 1mg (one 1mg tablet) once daily starting on day 5. ☐ Maintenance dose of 2mg is 2mg (one 2mg tablet) once daily starting on day 6.	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Ponvory™ (ponesimod) 1st dose observation: Date: _____ ☐ Not applicable	☐ Starter Pack (two 2mg tablets; two 3mg tablets; two 4mg tablets; 5mg tablet; 6mg tablet; 7mg tablet; 8mg tablet; 9mg tablet; three 10mg tablets) ☐ Maintenance 20mg tablet	☐ Starting Titration Take dose per schedule below by mouth once daily. Days 1 & 2: take one 2mg tablet Days 3 & 4: take one 3mg tablet Days 5 & 6: take one 4mg tablet Day 7: take one 5mg tablet Day 8: take one 6mg tablet Day 9: take one 7mg tablet Day 10: take one 8mg tablet Day 11: take one 9mg tablet Days 12, 13 & 14: take one 10mg tablet ☐ Maintenance Dose Days 15 and after: take one 20mg tablet by mouth once daily.	☐ 14-day supply (1 starter pack) No refills ☐ 30-day supply (30 tablets, 1 bottle) ☐ 90-day supply (90 tablets, 3 bottles) ☐ 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.

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
☐ Tascenso ODT® (fingolimod) orally disintegrating tablets 1st dose observation: Date: _____ ☐ Not applicable	☐ 0.5mg orally disintegrating tablet ☐ 0.25mg orally disintegrating tablet	☐ [Patients >10 years, weighing >40kg] Dissolve one 0.5mg tablet by mouth once daily. ☐ [Patients >10 years, weighing <40kg] Dissolve one 0.25mg tablet by mouth once daily. Date of first dose monitoring: _____ ☐ Not applicable	☐ 30-day supply #30 ☐ 90-day supply #90 Refills _____
☐ Zeposia® (ozanimod) 1st dose observation: Date: _____ ☐ Not applicable	☐ Starter Kit (therapy initiation) (four 0.23mg and three 0.46mg and thirty 0.92mg capsules) ☐ 0.92mg capsule (maintenance) ☐ 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, then one 0.92mg capsule daily thereafter. ☐ Take one capsule daily. ☐ Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule daily for 3 days. ☐ Other _____	☐ 4 week supply (1 kit) No refills ☐ 30 capsules = 30 days (1 bottle) Refills _____ ☐ 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.

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.

EVERNORTH HEALTH SERVICES