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–Self-administered Immunosuppressive

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): _____ Patient wt _____ Date wt obtained _____

To expedite referral processing, please attach the following (as applicable): liver function tests, blood chemistries, complete blood counts, latent infection screenings (HIV, Hep B/C, TB, etc), other relevant cardiac and medical history.

Pregnancy test _____ (+/-) Date _____

Expected date of first/next dose _____ Date of last dose (if applicable) _____

☐ 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
☐ Aubagio® (teriflunomide)	☐ 7mg tablet ☐ 14mg tablet	☐ Take one 7mg tablet by mouth once a day. ☐ Take one 14mg tablet by mouth once a day.	☐ 30-day supply ☐ 90-day supply ☐ Other _____ Refills _____
☐ Kesimpta® (ofatumumab)	20mg (0.4mL) prefilled pen	☐ Loading dose: Inject contents of 1 pen subcutaneously at weeks 0, 1 and 2, then maintenance dose of 20mg once monthly beginning at week 4. ☐ Maintenance dose: Inject contents of 1 pen subcutaneously (0.4mL) once monthly.	☐ 4-week supply ☐ 12-week supply Refills _____
☐ Mavenclad® (cladribine)	10mg tablet	Treatment course: ☐ Year 1 ☐ Year 2 ☐ 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

Weight Range (kg)	Number of 10mg tablets per week												
	Week 1						Week 5						
	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	Total Tablets
☐ 40 to <50	1	1	1	1	0	**4**	1	1	1	1	0	**4**	8 (80mg)
☐ 50 to <60	1	1	1	1	1	**5**	1	1	1	1	1	**5**	10 (100mg)
☐ 60 to <70	2	1	1	1	1	**6**	2	1	1	1	1	**6**	12 (120mg)
☐ 70 to <80	2	2	1	1	1	**7**	2	2	1	1	1	**7**	14 (140mg)
☐ 80 to <90	2	2	2	1	1	**8**	2	2	1	1	1	**7**	15 (150mg)
☐ 90 to <100	2	2	2	2	1	**9**	2	2	2	1	1	**8**	17 (170mg)
☐ 100 to <110	2	2	2	2	2	**10**	2	2	2	2	1	**9**	19 (190mg)
☐ 110 and above	2	2	2	2	2	**10**	2	2	2	2	2	**10**	20 (200mg)

☐ Other instructions: _____

☐ 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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