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Prescription & Enrollment Form Multiple Sclerosis (T-Z)

accredo®

Four simple steps to submit your referral.

1 Patient Information



Please attach copies of front and back of the patient's medical and prescription insurance cards.

New patient Current patient

Patient's first name _____ Last name _____ Middle initial _____

Male Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

OK to leave message with alternate caregiver/contact

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

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

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

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Infusion clinic name _____ Office/Infusion clinic affiliation _____

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 _____

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
<input type="checkbox"/> Tecfidera™ (dimethyl fumarate)	<input type="checkbox"/> Titration Starter Pack (14 capsules of 120mg and 46 capsules of 240mg) <input type="checkbox"/> 240mg capsules (#60 per bottle 30 day supply) <input type="checkbox"/> 120mg capsules (#14 per bottle 7 day supply)	<input type="checkbox"/> Titration Starter Pack: take 120mg capsule by mouth twice a day for 7 days followed by 240mg capsule by mouth twice a day. <input type="checkbox"/> Maintenance dose: take 240mg capsule by mouth twice a day. <input type="checkbox"/> Other _____	<input type="checkbox"/> Titration Starter Pack: 30-days <input type="checkbox"/> Maintenance dose (240mg): Supply: <input type="checkbox"/> 30-day <input type="checkbox"/> 90-day <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> dimethyl fumarate	<input type="checkbox"/> Titration Starter Pack (14 capsules of 120mg and 46 capsules of 240mg) <input type="checkbox"/> 240mg capsules (#60 per bottle 30 day supply) <input type="checkbox"/> 120mg capsules (#14 per bottle 7 day supply)	<input type="checkbox"/> Titration Starter Pack: take 120mg capsule by mouth twice a day for 7 days followed by 240mg capsule by mouth twice a day. <input type="checkbox"/> Maintenance dose: take 240mg capsule by mouth twice a day. <input type="checkbox"/> Other _____	<input type="checkbox"/> Titration Starter Pack: 30-days <input type="checkbox"/> Maintenance dose (240mg): Supply: <input type="checkbox"/> 30-day <input type="checkbox"/> 90-day <input type="checkbox"/> Other _____ Refills _____
Tysabri® (natalizumab)	Tysabri® is available only through the TOUCH™ Prescribing Program. Please call 800.456.2255 or go to www.tysabri.com.		
<input type="checkbox"/> Vumerity™ (diroximel fumarate)	<input type="checkbox"/> 231mg delayed-release capsules	<input type="checkbox"/> Starting dose: take 231mg capsule twice a day for 7 days. <input type="checkbox"/> Maintenance dose after 7 days: 462mg (administered as two 231mg capsules) twice a day, orally.	Supply: <input type="checkbox"/> 30-day <input type="checkbox"/> 90-day <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Zeposia® (ozanimod)	<input type="checkbox"/> Starter Kit (therapy initiation) (four 0.23mg and three 0.46mg and thirty 0.92mg capsules) <input type="checkbox"/> 0.92mg capsule (maintenance) <input type="checkbox"/> Starter pack (re-titration only) (four 0.23mg and three 0.46mg capsules)	<input type="checkbox"/> 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. <input type="checkbox"/> Take one capsule daily. <input type="checkbox"/> Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule daily for 3 days. <input type="checkbox"/> Other _____	<input type="checkbox"/> 4 week supply (1 kit) No refills <input type="checkbox"/> 30 capsules = 30-days (1 bottle) Refills _____ <input type="checkbox"/> 7-day supply (1 pack) No refills
<input type="checkbox"/> Other _____ _____			Supply: <input type="checkbox"/> 30-day <input type="checkbox"/> 90-day <input type="checkbox"/> Other _____ Refills _____

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

PHYSICIAN SIGNATURE REQUIRED

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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