Please fax both 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.

Prescription & Enrollment Form

Arthritis and Inflammatory — Subcutaneous

accredo®

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 ______

Sex at birth: Male Female 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 ______

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): ______

Has the patient been treated previously for this condition? Yes No Is patient currently on therapy? Yes No

Please list all therapies tried/failed: ______

Patient wt ______ Date wt obtained ______

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
Actemra® (tocilizumab)	Actemra Actpen 162mg/0.9mL Actemra 162mg/0.9mL Prefilled Syringe	**Rheumatoid Arthritis (RA):** 162mg subcutaneously once every week (greater than or equal to 100kg) 162mg subcutaneously every other week (less than 100kg) **Polyarticular Juvenile Idiopathic Arthritis (PJIA):** 162mg/dose subcutaneously once every 3 weeks (2 years or older, Less than 30kg) 162mg/dose subcutaneously once every 2 weeks (2 years or older, 30kg or greater) **Systemic Juvenile Idiopathic Arthritis (SJIA):** 162mg/dose subcutaneously once every 2 weeks. (2 years or older, Less than 30kg) 162mg/dose subcutaneously once every week. (2 years or older, 30kg or greater) **Giant cell arteritis:** 162mg subcutaneously once every week	1-month supply. Refill x 1 year unless noted otherwise. 90-day supply. Refill x 1 year unless noted otherwise. Other ______ Refills ______
Orencia® (abatacept)	125mg/mL PFS 125mg/mL Clickject Autoinjector	**Rheumatoid Arthritis (RA):** Inject 125mg subcutaneously once weekly	1-month supply. Refill x 1 year unless noted otherwise. 90-day supply. Refill x 1 year unless noted otherwise. Other ______ Refills ______
	50mg/0.4mL PFS 87.5mg/0.7mL PFS 125mg/mL PFS 125mg/mL Clickject Autoinjector	**Juvenile Idiopathic Arthritis (JIA):** 50mg subcutaneously once weekly (2 years and older and weighing 10kg to less than 25kg) 87.5mg subcutaneously once weekly (weight 25kg or less than 50kg) 125mg PFS subcutaneously once weekly (weight greater than or equal to 50kg) 125mg Clickject Autoinjector subcutaneously once weekly (weight greater than or equal to 50kg)	
Simponi® (golimumab)	Simponi 50mg/0.5mL Autoinject Pen Simponi 50mg/0.5mL Syringe	50mg subcutaneously once per month	1-month supply. Refill x 1 year unless noted otherwise. 90-day supply. Refill x 1 year unless noted otherwise. Other ______ Refills ______
Other			1-month supply. Refill x 1 year unless noted otherwise. 90-day supply. Refill x 1 year unless noted otherwise. Other ______ Refills ______

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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