Please fax both pages of completed form to your team at 800.330.0756.

To reach your team, call toll-free 866.712.5200.

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

Bleeding disorders

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 Preferred pronouns ______ 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 ______

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 e-mail ______

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 ______ E-mail ______

3 Clinical Information

Primary ICD-10 code (REQUIRED): ______ Bleeding disorder type: A B vWD Other ______

Severity: Mild Moderate Severe Type vWD ______

Height ______ Weight ______ Date obtained ______

IV access: PIV/butterfly PICC Implanted port Central line Inhibitor: No Yes (______ B.U.)

Target joint(s): No Yes Location ______ NKDA Known drug allergies ______

Concurrent meds ______

Additional clinical information ______

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

Prescriber's first name ______ Last name ______ Phone ______

4 Prescribing Information

Clotting factor orders—Complete this form OR attach prescription below.

Brand name	Units/kg	Qty	Frequency	Refills
Brand name ______	Units/kg ______	Qty ______	Frequency ______	Refills ______
Brand name ______	Units/kg ______	Qty ______	Frequency ______	Refills ______
Brand name ______	Units/kg ______	Qty ______	Frequency ______	Refills ______

Mild Bleeding use: Units/kg ______

Severe Bleeding use: Units/kg ______

Prophylaxis: Dispense ______ doses/week

Episodic: Dispense ______ doses for mild/______ doses for severe

Ancillary medications/supplies/nursing

Medication	Qty / Frequency / Refills
Aminocaproic Acid ______ mg tablets 500mg 1000mg tablets Oral solutions 250mg/mL Directions ______	Qty ______ Frequency ______ Refills ______
Desmopressin Acetate Solution 1.5mg/mL spray in: one nostril each nostril (2 sprays total)	Qty ______ Frequency ______ Refills ______
Tranexamic Acid 650mg tablets Directions ______	Qty ______ Frequency ______ Refills ______
Emla® Apply topically as needed to IV site 60 minutes prior to insertion prn and cover with occlusive dressing.	Qty ______ Frequency ______ Refills ______
LMX™ Apply topically as needed to IV site 30–60 minutes prior to insertion prn and cover with occlusive dressing.	Qty ______ Frequency ______ Refills ______

Heparin ______ units/mL ______ flush Qty ______ Frequency ______ Refills ______

Saline ______ mL flush Qty ______ Frequency ______ Refills ______

Other ______ Qty ______ Frequency ______ Refills ______

Skilled nursing visits to be provided for infusions Skilled nursing visits to be provided for teaching

Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, infusion device, etc. to administer the therapy as needed.

Attach prescription form here.

Refill x ______

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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