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

Pediatric Endocrine Disorders

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'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): _____ Weight (kg) _____ Height (cm) _____

Date measured _____ Injection training needed: ☐ Yes ☐ No By: ☐ MD office ☐ Other _____

If prior HgH use, date started _____ ☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Please attach the following information for growth disorder diagnosis: Drug profile, labs, growth chart where applicable

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
☐ Fensolvi® (leuprolide acetate injection suspension, extended release)	☐ 45mg syringe (180-day)	☐ Inject one syringe under the skin every 6 months.	☐ 1 syringe carton ☐ Other _____ Refills _____
☐ leuprolide acetate [14-day kit]	☐ 5mg/mL, 2.8mL multi-dose vial (14-day kit)		☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Lupron Depot Ped® (leuprolide acetate kit)	**One-month kit:** ☐ 7.5mg (1-mo) ☐ 11.25mg (1-mo) ☐ 15mg (1-mo) **Three-month kit:** ☐ 11.25mg (3-mo) ☐ 30mg (3-mo) **Six-month kit:** ☐ 45mg (6-mo)	☐ Inject one syringe intramuscularly at prescribed formulation frequency.	☐ 1 syringe kit ☐ Other _____ Refills _____
☐ Other			☐ 1-month supply ☐ 3-month 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 or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

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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