Please fax both pages of completed form to your endo 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

HIV metabolic support

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 # _____

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic Clinic location _____

3 Clinical Information

Primary ICD-10 code: B20 Human immunodeficiency virus [HIV] disease ❑ R64 Cachexia (Serostim® only) ❑ E88.1 Lipodystrophy (Egrifta® only)

Weight (kg) _____ Height (cm) _____ Date measured _____

BMI (kg/m^2) _____ Blood fasting glucose (mg/dL) _____ Waist circumference (cm) _____ Hip circumference (cm) _____

Waist-to-hip ratio (waist-to-hip ratio = waist circumference ÷ hip circumference) _____

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
❑ Egrifta SV®	2mg vials and administration kit	❑ Inject 1.4mg (0.35mL) under the skin daily. Discard any remaining portion. ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Serostim® (somatropin)	❑ 4mg multi-dose vial (MDV) with bacteriostatic water for injection ❑ 5mg single dose vial (SDV) with sterile water for injection ❑ 6mg SDV with sterile water for injection ❑ Alternate 4mg vial diluent: sterile water for injection (to use 4mg vial as single use)	Inject _____ mg under the skin once daily at bedtime	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
Serostim ancillary supplies: Needle and Syringe: 3 cc syringe, with 20G, 1" needles for reconstitution And one of the following for injection: ❑ 27G, 1/2" needles ❑ 29G, 1/2" needles ❑ 30G, 1/2" needles			Send quantity sufficient for medication days supply
❑ Other _____ _____			

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

I certify that this medication is not being prescribed for anti-aging, cosmetic or athletic performance. I further certify human growth hormone is being prescribed for the medical condition noted above and is medically necessary.

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

SIGN HERE PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____

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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