**Please fax both pages of completed form to your Oncology 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

# Oncology (oral) (E–S)

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 Preferred 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/lbs Height _____ cm/in BSA _____ $m^2$ Date recorded _____

☐ 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 |
|---|---|---|---|
| ☐ Erleada® (apalutamide) | ☐ 60mg tablets<br>☐ 240mg tablet | ☐ 240mg (four 60mg tablets) orally once daily<br>☐ 240mg (1 tablet) orally once daily | Quantity _____<br>Days supply _____<br>Refills _____ |
| ☐ Lorbrena® (lorlatinib) | ☐ 25mg tablet<br>☐ 100mg tablet | ☐ Take _____ mg orally twice daily<br>☐ Other _____ | Quantity _____<br>Days supply _____<br>Refills _____ |
| ☐ Promacta® (eltrombopag) | ☐ 12.5mg tablet<br>☐ 25mg tablet<br>☐ 50mg tablet<br>☐ 75mg tablet | ☐ Take _____ tablet(s) orally twice daily<br>☐ Other _____ | Quantity _____<br>Days supply _____<br>Refills _____ |
| ☐ Sprycel® (dasatinib) | ☐ 20mg tablet<br>☐ 50mg tablet<br>☐ 70mg tablet<br>☐ 80mg tablet<br>☐ 100mg tablet<br>☐ 140mg tablet | ☐ Take one tablet orally daily<br>☐ Other _____ | Quantity _____<br>Days supply _____<br>Refills _____ |
| ☐ Sutent® (sunitinib malate) | ☐ 12.5mg capsule<br>☐ 25mg capsule<br>☐ 37.5mg capsule<br>☐ 50mg capsule | ☐ Take one capsule orally daily continuously<br>☐ Take _____ capsule(s) orally daily 4 weeks on and 2 weeks off<br>☐ Other _____ | Quantity _____<br>Days supply _____<br>Refills _____ |
| ☐ Other _____ | _____ | _____ | Quantity _____<br>Days supply _____<br>Refills _____ |
| ☐ Other _____ | _____ | _____ | Quantity _____<br>Days supply _____<br>Refills _____ |

**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**

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