Please fax all 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

Oncology (oral) (T–Z)

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 _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ 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
☐ Talzenna® (talazoparib)	☐ 0.1mg capsule ☐ 0.25mg capsule ☐ 0.35mg capsule ☐ 0.5mg capsule ☐ 0.75mg capsule ☐ 1mg capsule	☐ Take _____ mg by mouth daily ☐ Other _____ A dose titration/reduction can be prescribed in order to manage tolerability.	Quantity _____ Days supply _____ Refills _____
☐ Tasigna® (nilotinib)	☐ 50mg capsule ☐ 150mg capsule (28 capsules per pack) ☐ 200mg capsule (28 capsules per pack)	☐ Take _____mg twice daily ☐ Other _____	Quantity _____ Days supply _____ Refills _____
☐ temozolomide	☐ 5mg capsule _____ qty ☐ 20mg capsule _____ qty ☐ 100mg capsule _____ qty ☐ 140mg capsule _____ qty ☐ 180mg capsule _____ qty ☐ 250mg capsule _____ qty	☐ Take _____mg once daily for _____ days on and _____ days off ☐ Other _____ Please see "Other" below to prescribe antiemetic agent if necessary.	Days supply _____ Refills _____
☐ lapatinib	☐ 250mg tablet	☐ Take 5 tablets once daily ☐ Other _____	Quantity _____ Days supply _____ Refills _____
☐ Vizimpro® (dacomitinib)	☐ 15mg tablet ☐ 30mg tablet ☐ 45mg tablet	☐ Take _____mg once daily ☐ Other _____	Quantity _____ Days supply _____ Refills _____
☐ pazopanib	☐ 200mg tablet	☐ Take 4 tablets once daily ☐ Other _____	Quantity _____ Days supply _____ Refills _____
☐ Xalkori® (crizotinib)	☐ 200mg capsule _____ qty ☐ 250mg capsule _____ qty ☐ 20mg oral pellets _____ qty ☐ 50mg oral pellets _____ qty ☐ 150mg oral pellets _____ qty	☐ Take _____mg twice daily ☐ Other _____	Days supply _____ Refills _____
☐ capecitabine	☐ 150mg tablet _____ qty ☐ 500mg tablet _____ qty	☐ Take _____mg twice daily for _____days with _____days off ☐ Other _____	Days supply _____ Refills _____
☐ Xtandi® (enzalutamide)	☐ 40mg capsule ☐ 40mg tablet ☐ 80mg tablet	☐ Take _____mg once daily ☐ Other _____	Quantity _____ Days supply _____ Refills _____
☐ Other _____			Quantity _____ Days supply _____ Refills _____

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.

accredo®