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

Rheumatoid arthritis—Intravenous (A-Q)

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/clinic/institution name _____ Clinic/hospital 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: _____

Has the patient been treated previously for this condition? ❑ Yes ❑ No Is patient currently on therapy? ❑ Yes ❑ No

Please list all therapies tried/failed: _____

_____

❑ Patient wt _____ ❑ Date wt obtained _____

❑ 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
❑ Actemra® (tocilizumab)	❑ 4mg/kg intravenous infusion every 4 weeks. Maximum dose of 800mg/infusion ❑ 8mg/kg intravenous infusion every 4 weeks. Maximum dose of 800mg/infusion	Dilute desired dose with normal saline to a total volume of 100mL to be infused over 1 hour.	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Avsola® (infliximab-axxq)	❑ 3mg/kg at 0, 2 and 6 weeks, then every 8 weeks ❑ 10mg/kg every 4 weeks	100mg of lyophilized infliximab-axxq in a 20mL single-dose vial for intravenous infusion over a period of not less than 2 hours.	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Orencia® (abatacept)	❑ 500mg (less than 60kg) ❑ 750mg (60–100kg) ❑ 1000mg (over 100kg) ❑ Juvenile arthritis 10mg/kg if less than 75kg **Starting dose:** ❑ at week: 0, 2 and 6, then every 4 weeks **Maintenance dose:** ❑ every 4 weeks	Reconstitute each vial of Orencia with 10mL of sterile water. Dilute desired dose to total of 100mL in normal saline to be infused over 30 minutes.	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Other _____ _____ _____ _____ _____ _____			Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____

Complete the below information if assistance from Accredo is requested in the coordination of your patient's infusion therapy.

Preferred infusion setting: ❑ Home ❑ Infusion clinic

Premedication orders ❑ Acetaminophen 650mg PO 30 min prior to infusion ❑ Diphenhydramine 50mg PO 30 min prior to infusion ❑ Hydrocortisone 100mg IV PO 30 min prior to infusion ❑ Other _____	1-month supply Refill x 1 year unless noted otherwise ❑ Other _____
Hypersensitivity/anaphylaxis orders ❑ Stop infusion ❑ Start normal saline at TKO	
Medicate with: ❑ Epinephrine/EpiPen® 0.3mg IM as needed for anaphylaxis. ❑ Diphenhydramine 50mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if there is no IV access. ❑ Hydrocortisone 100mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM in there is no IV access. ❑ Solumedrol 125mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if there is no IV access.	1-month supply Refill x 1 year unless noted otherwise ❑ Other _____
For anaphylactic reaction, activate 911. Notify physician of type reaction and action taken. Verbal report and transfer care to EMS, if applicable.	
Flushing orders ❑ Peripheral access ❑ Central venous access ❑ 0.9% sodium chloride flush with _____ mL IV before and after medication and IVP for maintenance. Administer IM in there is no IV access. ❑ Heparin _____ units per mL. Flush with _____ units as final flush and as directed.	1-month supply Refill x 1 year unless noted otherwise ❑ Other _____
Lab orders _____ ❑ Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. Dispense 1 month of drug, flushes, needles, syringes, ancillary supplies and medical equipment necessary to establish access and administer medication.	

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 (sign below) **(Physician attests this is his/her legal signature. NO STAMPS)** **PHYSICIAN SIGNATURE REQUIRED**

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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