Please fax both pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.412.4764.

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

Rinvoq® (upadacitinib)

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 _____

☐ 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 phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Patient weight _____ Date weight taken _____

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
☐ Rinvoq® (upadacitinib) Atopic dermatitis	☐ 15mg	Take 1 tablet (15mg) by mouth once daily	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
	☐ 30mg	Take 1 tablet (30mg) by mouth once daily (inadequate response to 15mg dose)	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Rinvoq® (upadacitinib) Psoriatic Arthritis	15mg	Take 1 tablet by mouth once daily	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Rinvoq® (upadacitinib) Rheumatoid Arthritis	15mg	Take 1 tablet by mouth once daily	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Rinvoq® (upadacitinib) Ulcerative Colitis	Loading Dose ☐ 45mg	Take 1 tablet (45mg) by mouth once daily for 8 weeks	1-month supply (28 ct bottle) 1 refill
	Maintenance Dose ☐ 15mg ☐ 30mg	☐ Take 1 tablet (15mg) by mouth once daily ☐ Take 1 tablet (30mg) by mouth once daily (for patients with refractory, severe, or extensive disease)	☐ 1-month supply ☐ 3-month supply ☐ Other _____ 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**

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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