Prescription & Enrollment Form

Samsca®

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current patient

Patient's first name _____

Last name _____ Middle initial _____

Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____

Street address _____ Apt # _____

City _____ State ____ Zip _____

Parent/guardian (if applicable) _____

Cell phone _____

Other phone _____

E-mail address _____

Patient's primary language: ❑ English ❑ Other

If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____

Phone _____

Insured's name _____

Insured's employer _____

Relationship to patient _____

Identification # _____

Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____

Group # _____

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

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 contact and title _____

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: ❑ E87.1 Hypo-osmolality and hyponatremia

❑ E22.2 Syndrome of inappropriate secretion of antidiuretic hormone

❑ Other _____

Secondary diagnoses: _____

❑ NYHA CHF class _____ ❑ DM ❑ CKD ❑ ASCVD

Relevant PMH _____

Patient weight (kg) _____ Date of weight _____

❑ NKDA ❑ Known drug allergies _____

Concomitant medications _____

Most recent hospitalization:

Baseline serum sodium _____ (attach most recent labs to referral)

Baseline urine osmolality _____

Inpatient therapy start date _____ Doses received _____

Hospital discharge date _____

Prior hyponatremia therapy:

❑ Fluid restriction _____ L/day Stop date _____

❑ Vasopressin receptor antagonist ❑ Demeclocycline ❑ 3% saline

❑ Other _____ Stop date _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Samsca® (tolvaptan)	❑ 15 mg tablets ❑ 30 mg tablets	Titration: Initiation and re-initiation of therapy should occur in the hospital to evaluate therapeutic response and prevent osmotic demyelination from over-correction of hyponatremia. ❑ Maintenance dose: Take _____ mg by mouth once daily.	Dispense: ❑ No more than 30 days supply* Refills _____ *Note: Do not administer Samsca for more than 30 days to minimize the risk of liver injury.
❑ tolvaptan	❑ 15 mg tablets ❑ 30 mg tablets	Titration: Initiation and re-initiation of therapy should occur in the hospital to evaluate therapeutic response and prevent osmotic demyelination from over-correction of hyponatremia. ❑ Maintenance dose: Take _____ mg by mouth once daily.	Dispense: ❑ No more than 30 days supply* Refills _____ *Note: Do not administer Samsca for more than 30 days to minimize the risk of liver injury.

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

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

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

_____ _____ _____ _____

Date Substitution allowed Date Dispense as written

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.

Please fax completed form to 877.251.9381.

To reach your team, call toll-free 855.891.7977.

You can now monitor shipments and chat online if you have questions.

Go to MyAccredoPatients.com to log in or get started.