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

Xipere™ (triamcinolone acetonide injectable suspension)

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/Clinic/Institution Name _____

Office address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Infusion clinic name _____ Office/Infusion clinic affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Infusion clinic contact name _____

E-mail _____ Deliver product to: ☐ Office ☐ Patient's home ☐ Clinic

Clinic location _____

3 Clinical Information

Primary ICD-10 code: ☐ Macular Edema H35.81 ☐ Other _____

☐ 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
☐ Xipere™ (triamcinolone acetonide injectable suspension)	4mg/0.1mL vial	Inject 4mg suprachoroidally into affected eye(s) as directed	Dispense: ☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Other			

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

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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