REFILL SHIP REQUEST FORM
Complete form and fax to 888.302.1028

accredo®

Patient Name (Full First, Last Middle Initial): ____________________
Date of Birth: ____________________
Insurance ID: ____________________
Primary Insurance Name: ____________________

Medication Name: ____________________ Medication Strength: ____________________

Contact 844.516.3319 when the following applies, DO NOT COMPLETE FORM:

- Order needed within 5 business days
- Change of insurance or copay assistance
- Shipment address is different for next fill
- Change in drug, dose, strength
- New prescription or other changes
- Discontinue shipments for this patient
- Patient not recently seen by prescriber
- No longer a patient
- Every 6 months or once a year fill

NEW RX? Fax to 888.302.1028. Once processing is complete, Accredo will call the patient to coordinate delivery.

If the above does NOT apply, COMPLETE THE INFORMATION BELOW:

Physician Name (Full First, Last): ____________________
Physician NPI: ____________________
Delivery Address: ____________________
City: ____________________ State: ____________________ ZIP: ____________________
Phone Number: ____________________
Delivery Date for Medication: ____________________

Special delivery or other instructions: ____________________
Are additional ancillaries needed? If yes, note ancillary needed: ____________________
Office representative's name completing the form (Print): ____________________
Patient/Caregiver signature consenting to ship next order: ____________________

To prevent an interruption or delay in your patient's therapy, please read the following information:

- Patient's signature is required on this form to schedule next shipment to the site of administration. Signature serves as the Patient Ship Authorization.
- Patient with a PSA (Patient Ship Authorization) on file with Accredo for the life of the current prescription will not be called to schedule their order.
- DO NOT COPY or send multiple faxes for this patient at one time. ORIGINAL form must be faxed each time a refill shipment is needed. Action includes patients with a PSA for the life of the script on file.
- Prescriber will receive an INVALID notification fax for any incomplete or invalid refill ship request form. A fax communication will indicate next steps needed to complete scheduling of next shipment.
- In the absence of a completed refill shipment request form, the patient or prescriber may be contacted for a verbal authorization for each shipment.
- Refill Ship Request Form used for shipments delivered to Health Care Provider or Facilities ONLY (Home Health services excluded).
- Any unpaid balances may delay your patient's order. Provide statement generated with shipment as patient will be responsible to maintain all appropriate balances.
- The prescriber is to comply with his/her state specific prescription requirements, including appropriate storage and security.

You can monitor shipments and chat online. Go to MyAccredoPatients.com to log in or get started.