

Please fax all pages of completed form to your team at 888.454.8488.

To reach your team, call toll-free 844.492.4941.

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# Prescription & Enrollment Form

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 \_\_\_\_\_

Preferred patient first name \_\_\_\_\_ Preferred patient last name \_\_\_\_\_

Sex at birth:    Male    Female    Gender identity \_\_\_\_\_    Pronouns \_\_\_\_\_    Last 4 digits of SSN \_\_\_\_\_

Date of birth \_\_\_\_\_ Street address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Parent/guardian (if applicable) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Alternate caregiver/contact \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email 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 \_\_\_\_\_

Office/clinic/institution name \_\_\_\_\_

**Prescriber info:** 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 email \_\_\_\_\_

Office street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Infusion location:    Patient's home    Prescriber's office    Infusion site    If infusion site, complete information below dotted line:

**Infusion info:** Infusion site name \_\_\_\_\_ Clinic/hospital affiliation \_\_\_\_\_

Site street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Infusion site contact \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

## 3 Clinical Information

**Primary ICD-10 code (REQUIRED):** \_\_\_\_\_

NKDA    Known drug allergies \_\_\_\_\_

Concurrent meds \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_ Phone \_\_\_\_\_