Please fax both pages of completed form to your team at 888.302.1028.
To reach your team, call toll-free 844.516.3319.
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

Crohn's Disease—Humira and Biosimilars

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): ______ Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No Please list all therapies tried/failed: ______

______

Patient wt ______ Date wt obtained ______

☐ 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
☐ Amjevita™ (adalimumab-atto) Citrate Free **(ADULT)**	☐ 40mg/0.8mL SureClick Autoinjector ☐ 40mg/0.8mL prefilled syringe (PFS)	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Amjevita™ (adalimumab-atto) Citrate Free **(PEDIATRIC)** Patient weight is required for pediatric patients: _____ kg	☐ 40mg/0.8mL SureClick Autoinjector ☐ 40mg/0.8mL PFS	**Loading dose:** **For 17kg to less than 40kg:** ☐ Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 **For 40kg or greater:** ☐ Inject 160mg day 1 --OR-- ☐ Inject 80mg each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
	☐ 20mg/0.4mL PFS	**Maintenance dose:** **For 17kg to less than 40kg:** ☐ Inject 20mg subcutaneously every other week **For 40kg or greater:** ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
	☐ 40mg/0.8mL SureClick Autoinjector ☐ 40mg/0.8mL PFS		
☐ Cyltezo® (adalimumab-adbm) Citrate Free **(ADULT)**	☐ 40mg/0.8mL pen ☐ 40mg/0.8mL PFS	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

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.

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
☐ Cyltezo® (adalimumab-adbm) Citrate Free **(PEDIATRIC)** Patient weight is required for pediatric patients: _____ kg	☐ 40mg/0.8mL pen ☐ 40mg/0.8mL PFS	**Loading dose:** **For 17kg to less than 40kg:** ☐ Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 **For 40kg or greater:** ☐ Inject 160mg day 1 --OR- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	1 starter kit -OR- QS for 1-month loading dose No Refills
	☐ 20mg/0.4mL PFS	**Maintenance Dose:** **For 17kg to less than 40kg:** ☐ Inject 20mg subcutaneously every other week **For 40kg or greater:** ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
	☐ 40mg/0.8mL pen ☐ 40mg/0.8mL PFS		
☐ adalimumab-adbm Citrate Free **(ADULT)**	☐ 40mg/0.8mL pen ☐ 40mg/0.8mL PFS	**Loading dose:** **For 17kg to less than 40kg:** ☐ Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 **For 40kg or greater:** ☐ Inject 160mg day 1 --OR- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: **For 17kg to less than 40kg:** ☐ Inject 20mg subcutaneously every other week **For 40kg or greater:** ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Hadlima™ (adalimumab-bwwd) Citrate Free **(ADULT)**	☐ 40mg/0.8mL PFS ☐ 40mg/0.4mL PFS ☐ 40mg/0.8mL PushTouch Autoinjector ☐ 40mg/0.4mL PushTouch Autoinjector	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
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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.

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
☐ Humira® (adalimumab) **(ADULT)**	**Starter**: ☐ 80mg/0.8mL prefilled pen Starter Package (3 pens) ☐ 40mg/0.4mL PFS for starter dose	**Loading dose:** ☐ 160mg injected day 1 --OR-- ☐ 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1 starter kit -OR- QS for 1-month loading dose No Refills
	Maintenance: ☐ 40mg/0.4mL citrate-free pen ☐ 40mg/0.8mL pen ☐ 40mg/0.8mL PFS ☐ 40mg/0.4mL citrate-free PFS	**Maintenance Dose**: Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Idacio® (adalimumab-aacf) Citrate Free Patient weight is requested for pediatric patients: _____ kg	☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pen	**For Adults and Children 6 yrs and older weighing 40kg (88 lbs) and greater:** **Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		For Adults and Children 6 yrs and older weighing 40kg (88 lbs) and greater: **Maintenance Dose**: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Humira® (adalimumab) **(PEDIATRIC)** Patient weight is required for pediatric patients: _____ kg	**Starter**: ☐ 80mg/0.8mL PFS Starter Package (3 syringes) ☐ 40mg/0.4mL PFS for starter dose	**Loading dose:** ☐ 160mg injected day 1 --OR-- ☐ 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1 starter kit -OR- QS for 1-month loading dose No Refills
	☐ 80mg/0.8mL and 40mg/0.4mL citrate-free syringe starter package ☐ 40mg/0.4mL PFS for starter dose	**Loading dose:** 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29.	
	Maintenance: ☐ 40mg/0.4mL citrate-free pen ☐ 40mg/0.8mL PFS ☐ 80mg/0.8mL citrate-free pen ☐ 40mg/0.4mL citrate-free PFS ☐ 20mg/0.2mL PFS ☐ 40mg/0.8mL pen	**Maintenance Dose**: ☐ Inject 40mg subcutaneously every other week ☐ Inject 20mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

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.

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
☐ Hyrimoz® (adalimumab-adaz) Citrate Free **(ADULT)**	☐ 80mg/0.8mL Pen Starter Pack (3 pens)	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
	☐ 40mg/0.4mL pen ☐ 40mg/0.4mL PFS	**Maintenance Dose**: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ adalimumab-adaz Citrate Free **(ADULT)**	☐ 40mg/0.4mL pen ☐ 40mg/0.4mL PFS	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Hyrimoz® (adalimumab-adaz) Citrate Free **(PEDIATRIC)** Patient weight is required for pediatric patients: _____ kg	☐ 80mg/0.8mL and 40mg/0.4mL PFS Pediatric Crohn's Starter Pack (2 PFS) ☐ 80mg/0.8mL PFS Pediatric Crohn's Starter Pack (3 PFS)	**Loading dose:** **For 17kg to less than 40kg:** ☐ Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 **For 40kg or greater:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
	☐ 20mg/0.2mL PFS ☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL pen	**Maintenance Dose**: **For 17kg to less than 40kg:** ☐ Inject 20mg subcutaneously every other week **For 40kg or greater:** ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other			

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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.

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
☐ adalimumab-adaz Citrate Free **(PEDIATRIC)** Patient weight is required for pediatric patients: _____ kg	☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL pen	**Loading dose:** **For 17kg to less than 40kg:** ☐ Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 **For 40kg or greater:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: **For 17kg to less than 40kg:** ☐ Inject 20mg subcutaneously every other week **For 40kg or greater:** ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other			

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