## 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 <u>MyAccredoPatients.com</u> to log in or get started.

## Prescription & Enrollment Form Kevzara<sup>®</sup> (sarilumab) for PMR

accredo

Four simple steps to submit your referral.

<b>1</b> Patient Informat	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	
Sex at birth: Male Female Pre	eferred pronouns	Las	st 4 digits of SSN	Date of	of birth	
Street address					Apt #	
City		State		Ζ	/ip	
Home phone	Cell phone		Email a	ddress		
Parent/guardian (if applicable)						
Home phone	Cell phone		Email a	ddress		
Alternate caregiver/contact						
Home phone						
OK to leave message with alternat	e caregiver/contact					
Patient's primary language: Engli	sh Other If other	, please specify	ý			
<b>2</b> Prescriber Inform	nation		All fields must be co	mpleted to expedite pr	escription fulfillment.	
Date						
Office/clinic/institution name						
Prescriber info: Prescriber's first nar	ne		Last n	ame		
Prescriber's title		If NP	or PA, under directio	n of Dr		
Office phone	Fax		NPI #	License	#	
Office contact and title			Office c	ontact email		
Office street address						
City		State			_ Zip	
Infusion location: Patient's home	Prescriber's office	Infusion site	If infusion site, com	plete information below	w dotted line: 	
Infusion info: Infusion site name			Clinic/hospital af	filiation		
Site street address			-	S	uite #	
City		State			_ Zip	
Infusion site contact	Phone	e	Fax	Email		
<b>3</b> Clinical Informat	tion					
Primary ICD-10 code (REQUIRED): _		Has	the patient been tre	ated previously for this	condition? Yes	No
Is patient currently on therapy? Ye						
Patient wt	Date wt obtained					

Concurrent meds

Known drug allergies \_\_\_\_

NKDA

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
Kevzara® (sarilumab)	200mg/1.14mL prefilled pen 200mg/1.14mL prefilled syringe	Inject 200mg subcutaneously every 2 weeks	1-month supply 3-month supply Other Refills
Other	Other	Other	
, ,,	Content of the strike through if not required) y supplies such as needles, syringes, sterile water, etc. and home medierapy as needed.	cal equipment necessary to	Send quantity sufficient for medication days supply

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	
	If NP or PA, under direction of Dr		State Lic	cense No:	

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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