Please fax all pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

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

677 Ala Moana Blvd., Suite 404, Honolulu, HI 96813 5412

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	t patient		
Patient's first name		Last name	Middle initial
Preferred patient first name		Preferred pa	itient last name
Sex at birth: Male Fe	male Gender identity	Pronouns	Last 4 digits of SSN
Date of birth	Street address		Apt #
City		State	Zip
Home phone	Cell phone	En	nail address
Parent/guardian (if applicat	le)		
			nail address
Alternate caregiver/contact			
Home phone	Cell phone	En	nail address
OK to leave message wit	h 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 r	needed	
Office/clinic/institu	tion name					
Prescriber info: Pre	escriber's first nar	ne		La	st name	
Prescriber's title			If NP	or PA, under dire	ction of Dr	
Office phone		Fax		NPI #	Licen	ise #
Office contact and	title	Office contact email				
Office street addre	SS					Suite #
City			State			Zip
				,	complete information be	elow dotted line:
Infusion info: Infus	ion site name			Clinic/hospita	I affiliation	
Site street address						Suite #
City			State			Zip
Infusion site contact	t	Phon	e	Fax	Email	

3 Clinical Information

Primary ICD-10 code (REQUIRED):				
NKDA	Known drug allergies			
Concurrent meds				

Prescription & Enrollment Form

Fax completed	form to	808.650).6487
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Patient's first name	Last name	Middle initial	Date of birth
Prescriber's first name	Last name	Phone	

4 Prescribing Information

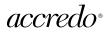
Medication	Strength/Formulation	Directions	Quantity/Refills
			1-month supply 3-month supply Other
			Refills
			1-month supply 3-month supply Other
			Refills
			1-month supply 3-month supply Other
			Refills
Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy		As needed for administration	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				
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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