## Please fax both 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 Gilotrif <sup>®</sup> (afatinib)			<i>accredo</i> ® 677 Ala Moana Blvd., Suite 404, Honolulu, HI 96813-5412			
Four simple steps to submit your referral.						
<b>1</b> Patient Information		Please provide copies of front and back of all medi and prescription insurance cards.				
New patient Current patient						
Patient's first name		Last name	Middle initial			
	•	-	Date of birth			
			Apt #			
•			Zip			
			·			
Home phone	Cell phone	Email address	·			
-						
Home phone	Cell phone	Email address				
OK to leave message with alternate of	-					
Patient's primary language: English	Other If other, pl	ease specify				
2 Prescriber Informa	ation	All fields must be complete	d to expedite prescription fulfillment.			
Date Tin	าย	Date medication needed				
Office/clinic/institution name						
Prescriber's first name		Last name				
Prescriber's title		If NP or PA, under direction of D	ſ			
Office phone	Fax	NPI #	License #			
			Suite #			
			Zip			
Deliver product to: Prescriber's office			Zip			
<b>3</b> Clinical Information	on					

Primary ICD	-10 code: (REQUIRED)		
Current weig	ht	_ kg/lbs Date obtained	
NKDA	Known drug allergies		
Concurrent i	meds		

## Prescription & Enrollment Form: Gilotrif® (afatinib)

Patient's first name	Last name	Middle initial	Date of birth
Prescriber's first name	Last name	Phone	

## **4** Prescribing Information

The patient has tested positive for EGFR mutation: Yes No

The	nationt h	~~ ~~		histology	Yes	Na
rne	patient n	as sq	uamous	histology:	res	No

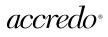
Medication	Dose	Directions	Quantity/Refills
Gilotrif® (afatinib)	40mg tablet 30mg tablet 20mg tablet	Take tablet(s) daily. Other	Dispense: 1-month supply 3-month supply Other Refills

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

## Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

 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.



SIGN

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