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 MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form Litfulo[™] (ritlecitinib)



Four simple steps to submit your referral.

Patient Information 1



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 p	patient last name
Sex at birth: Male Fem	ale Gender identity	Pronouns	Last 4 digits of SSN
Date of birth	Street address		Apt #
City		_ State	Zip
Home phone	Cell phone	E	Email address
Parent/guardian (if applicable	e)		
			Email address
Alternate caregiver/contact			
Home phone	Cell phone	E	Email address
OK to leave message with	alternate caregiver/contact		
Patient's primary language:	English Other If other, p	lease specify	

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date	Time	Dat	e medication need	ded
Office/clinic/institution name				
Prescriber's first name			Last name	
Prescriber's title		If NP or	PA, under directio	on of Dr
Office phone	Fax		NPI #	License #
Office contact and title			_ Office contact	email
Office street address				Suite #
City		State		Zip
Deliver product to: Prescriber's	office Patient's home			

Clinical Information 3

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 allergie	s				

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
Litfulo™ (ritlecitinib)	50mg Capsule	Take 50mg by mouth once daily	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other
Other			

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



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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