

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 MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form Nemluvio[®] (nemolizumab-ilto)

accredo[®]
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 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): _____

NKDA Known drug allergies _____

Prior anaphylactic reaction: No Yes (Reason/date _____)

Concurrent meds _____

Patient wt _____ kg Date wt obtained _____ Prescription type: Naïve/new start Restart Continued therapy

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength / Formulation and Directions	Quantity/Refills
Nemluvio® (nemolizumab-ilto) 30mg/0.49mL single dose dual chamber pen	For Adults weighing less than 90kg (198.4 lbs) Starter Dose: Inject 60mg under the skin on Day 1 then 30mg every 4 weeks starting on day 29 and thereafter. Maintenance Dose: Inject 30mg under the skin every 4 weeks. For Adults weighing 90kg (198.4 lbs) or greater Starter Dose: Inject 60mg under the skin on Day 1 then 60mg every 4 weeks starting on day 29 and thereafter. Maintenance Dose: Inject 60mg under the skin every 4 weeks.	Starter Dose: 2 pens No refills
		Maintenance Dose: 1-month supply 3-month supply Other _____ Refills _____
		Patient weight _____ kg

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)

**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.