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 Rheumatoid Arthritis – Oral



Four simple steps to submit your referral.

1 Patient Information

New patient Current patient			
Patient's first name	La:	st name	Middle initial
Sex at birth: Male Female Preferred	l pronouns L	.ast 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 care	egiver/contact		
Patient's primary language: English	Other If other, please spec	ify	

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Please provide copies of front and back of all medical

and prescription insurance cards.

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

3 Clinical Information

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 allergies _		
Concurrent n	neds		

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
Olumiant® (baricitinib)	2mg tablets	Take 2mg by mouth once a day	1-month supply Refill x1 year unless noted otherwise 3-month supply Refill x1 year unless noted otherwise Other Refills
Rinvoq® (upadacitinib)	15mg tablets	Take 15mg by mouth once a day	1-month supply Refill x1 year unless noted otherwise 3-month supply Refill x1 year unless noted otherwise Other Refills
Xeljanz® (Tofacitinib)	5mg tablets 11mg tablets XR 1mg/mL oral solution 240mL	Take 5mg by mouth twice a day Take 11mg by mouth once a day Take mg by mouth twice a day	1-month supply Refill x1 year unless noted otherwise 3-month supply Refill x1 year unless noted otherwise Other Refills
Otezla® (apremilast)	Starter dose: Starter Pack (28 day)	Starter dose:Day 1: Take by mouth 10mg in the morning.Day 2: Take by mouth 10mg in the morning and10mg in the evening.Day 3: Take by mouth 10mg in the morning and20mg in the evening.Day 4: Take by mouth 20mg in the morning and20mg in the evening.Day 5: Take by mouth 20mg in the morning and30mg in the evening.Day 5: Take by mouth 20mg in the morning and30mg in the evening.Day 6 and thereafter: Take by mouth 30mg inthe morning and 30mg in the evening	Starter dose: 1 Kit Other Refills
	Maintenance dose: 30mg tablets	Maintenance dose: Take 30mg by mouth twice a day Take 30mg by mouth once a day (severe renal impairment).	Maintenance dose: 1-month supply Refill x1 year unless noted otherwise 3-month supply Refill x1 year unless noted otherwise Other Refills
Other			

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



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.



Date

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