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

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 _____

Sex at birth: ☐ Male ☐ Female Preferred 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'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 _____

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 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
☐ 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 and 10mg in the evening. Day 3: Take by mouth 10mg in the morning and 20mg in the evening. Day 4: Take by mouth 20mg in the morning and 20mg in the evening. Day 5: Take by mouth 20mg in the morning and 30mg in the evening. Day 6 and thereafter: Take by mouth 30mg in the 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)

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.

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