

Please fax both pages of completed form to your PAH team at 800.711.3526.

To reach your team, call toll-free 888.200.2811.

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
Pirfenidone



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 _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail 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 e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to: Prescriber's office Patient's home

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____

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	Dose	Directions	Quantity/Refills
pirfenidone	Initial titration: 267mg tablets 267mg capsules	Initial titration: Days 1-7: 1 tablet by mouth 3 times/day with meals Days 8-14: 2 tablets by mouth 3 times/day with meals Days 15+: 3 tablets by mouth 3 times/day with meals Days 1-7: 1 capsule by mouth 3 times/day with meals Days 8-14: 2 capsules by mouth 3 times/day with meals Days 15+: 3 capsules by mouth 3 times/day with meals	1-month supply No refills
	Maintenance dose: 267mg tablets 267mg capsules	Maintenance dose: 3 tablets by mouth 3 times/day with meals 3 capsules by mouth 3 times/day with meals	1-month supply 3-month supply Other _____
	Maintenance dose: 801mg tablets	Maintenance dose: 1 tablet by mouth 3 times/day with meals Other _____	Refills _____
Other _____			1-month supply 3-month supply Other _____ Refills _____

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

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.