

Prescription & Enrollment Form

Anemia



Four simple steps to submit your referral.

1 PATIENT INFORMATION

New patient Current

Patient's name _____
 Date of birth _____ Male Female Last 4 digits of SSN _____
 Street address _____ Apt # _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____
 Home phone _____ Work phone _____
 Cell phone _____ Evening phone _____
 E-mail address _____
 Patient's primary language: English Other If other, please specify _____

Please attach front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
 Insured's name _____
 Insured's employer _____ Relationship to patient _____
 Identification # _____ Policy/group # _____
 Prescription card: Yes No If yes, carrier _____
 Policy # _____ Group # _____ Is patient eligible for Medicare? Yes No
 Does patient have a secondary insurance? Yes No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
 Prescriber's name and title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 Clinic/hospital affiliation _____
 Street address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI # _____ License # _____
 Deliver product to: Office Patient's home Clinic
 Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
 Current weight _____ kg/lbs Date recorded _____
 Laboratory results: Hematocrit _____ % Date _____
 Hemoglobin _____ g/dl Date _____
 Platelets _____ Date _____
 EXPECTED DATE OF FIRST/NEXT INJECTION _____
 DATE OF LAST INJECTION (if applicable) _____
 Agency nurse to visit home for injection: Yes No
 Agency name & phone _____
 NKDA Known drug allergies _____
 Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Directions	Quantity/Refills
<input type="checkbox"/> Aranesp® (darbepoetin alfa)	Inject dose _____ mcg/kg or _____ mcg Route: <input type="checkbox"/> IV <input type="checkbox"/> SC Dosing directions (include daily, weekly, cyclic, one-time, duration of txt., etc.) _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Epogen® (epoetin alfa)	Inject dose _____ units/kg or _____ units Route: <input type="checkbox"/> IV <input type="checkbox"/> SC Dosing directions (include daily, weekly, cyclic, one-time, duration of txt., etc.) _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Procrit® (epoetin alfa)		
<input type="checkbox"/> Retacrit™ (epoetin-alfa-ebpx)		
<input type="checkbox"/> Other _____ _____		Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
Supplies (if needed per dose): <input type="checkbox"/> 1 mL syringe <input type="checkbox"/> 3 mL syringe <input type="checkbox"/> 7G 5/8" needle <input type="checkbox"/> 25G 5/8" needle <input type="checkbox"/> 27 1/2G 5/8" needle – pediatrics only		Send quantity sufficient for medication days supply
<input type="checkbox"/> Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy as needed for administration.		Send quantity sufficient for medication days supply

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

By signing below, I certify that the above therapy is medically necessary.

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

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

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.

Please fax completed form to the Anemia team at 888.302.1028.

To reach your team, call toll-free 888.608.9010.

You can now track shipments for all your Accredo patients.
 Go to <https://prescribers.accredo.com> and click "Help" to register.

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