Prescription & Enrollment Form

Anemia

accredo®

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 _____

Hemaglobin _____ 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
❑ Aranesp® (darbepoetin alfa)	Inject dose _____ mcg/kg or _____ mcg Route: ❑ IV ❑ SC Dosing directions (include daily, weekly, cyclic, one-time, duration of txt., etc.) _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Epogen® (epoetin alfa) ❑ Procrit® (epoetin alfa) ❑ Retacrit™ (epoetin-alfa-ebpx)	Inject dose _____ units/kg or _____ units Route: ❑ IV ❑ SC Dosing directions (include daily, weekly, cyclic, one-time, duration of txt., etc.) _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Other _____ _____ _____		Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
Supplies (if needed per dose): ❑ 1 mL syringe ❑ 3 mL syringe ❑ 7G 5/8" needle ❑ 25G 5/8" needle ❑ 27 1/2G 5/8" needle – pediatrics only		Send quantity sufficient for medication days supply
❑ 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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