

Prescription & Enrollment Form
Oncology (oral) (A-S)



Four simple steps to submit your referral.

1 PATIENT INFORMATION

New patient Current

Patient's first name _____
 Last name _____ Middle initial _____
 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 copies of 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 first name _____ Last name _____
 Prescriber's title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 Office contact e-mail _____
 Office/clinic/institution name _____
 Clinic/hospital affiliation _____
 Street address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI # _____ License # _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
 Current weight _____ kg/lbs Height _____ inches/cm
 BSA _____ m² Date obtained _____
 NKDA Known drug allergies _____
 Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
<input type="checkbox"/> abiraterone acetate	<input type="checkbox"/> 250mg tablet <input type="checkbox"/> 500mg tablet	<input type="checkbox"/> Take 1000mg (four 250mg tablets or two 500mg tablets) orally once daily <input type="checkbox"/> Other _____ If patient is NOT currently receiving prednisone, prescribe below in "Other."	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Afinitor® (everolimus)	<input type="checkbox"/> 2.5mg tablet <input type="checkbox"/> 5mg tablet <input type="checkbox"/> 7.5mg tablet <input type="checkbox"/> 10mg tablet	<input type="checkbox"/> Take one tablet daily <input type="checkbox"/> Other _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Afinitor® DISPERZ (everolimus)	<input type="checkbox"/> 2mg tablet <input type="checkbox"/> 3mg tablet <input type="checkbox"/> 5mg tablet	<input type="checkbox"/> Dissolve _____ tablet(s) in water and drink daily <input type="checkbox"/> Other _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Erivedge® (vismodegib)	<input type="checkbox"/> 150mg capsule	<input type="checkbox"/> Take one capsule daily <input type="checkbox"/> Other _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> erlotinib	<input type="checkbox"/> 25mg tablet <input type="checkbox"/> 100mg tablet <input type="checkbox"/> 150mg tablet	<input type="checkbox"/> Take one tablet daily <input type="checkbox"/> Other _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> imatinib mesylate	<input type="checkbox"/> 100mg tablet <input type="checkbox"/> 400mg tablet	<input type="checkbox"/> Take _____ tablet(s) _____ time(s) a day <input type="checkbox"/> Other _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Jakafi® (ruxolitinib)	<input type="checkbox"/> 5mg tablet <input type="checkbox"/> 10mg tablet <input type="checkbox"/> 15mg tablet <input type="checkbox"/> 20mg tablet <input type="checkbox"/> 25mg tablet	<input type="checkbox"/> Take _____ tablet(s) twice daily <input type="checkbox"/> Other _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Lorbrena® (lorlatinib)	<input type="checkbox"/> 25mg tablet <input type="checkbox"/> 100mg tablet	<input type="checkbox"/> Take _____ mg once daily <input type="checkbox"/> Other _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Promacta® (eltrombopag)	<input type="checkbox"/> 12.5mg tablet <input type="checkbox"/> 25mg tablet <input type="checkbox"/> 50mg tablet <input type="checkbox"/> 75mg tablet	<input type="checkbox"/> Take _____ tablet(s) twice daily <input type="checkbox"/> Other _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Sprycel® (dasatinib)	<input type="checkbox"/> 20mg tablet <input type="checkbox"/> 50mg tablet <input type="checkbox"/> 70mg tablet <input type="checkbox"/> 80mg tablet <input type="checkbox"/> 100mg tablet <input type="checkbox"/> 140mg tablet	<input type="checkbox"/> Take one tablet daily <input type="checkbox"/> Other _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Sutent® (sunitinib malate)	<input type="checkbox"/> 12.5mg capsule <input type="checkbox"/> 25mg capsule <input type="checkbox"/> 37.5mg capsule <input type="checkbox"/> 50mg capsule	<input type="checkbox"/> Take one capsule daily continuously <input type="checkbox"/> Take _____ capsule(s) daily 4 weeks on and 2 weeks off <input type="checkbox"/> Other _____	Quantity _____ Days supply _____ Refills _____
<input type="checkbox"/> Other _____			Quantity _____ Days supply _____ Refills _____

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

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

PHYSICIAN SIGNATURE REQUIRED

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.

Please fax completed form to the Oncology team at 888.302.1028. To reach your team, call toll-free 844.516.3319.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

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