

Inflammatory bowel disease—self-injectable



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: _____
 Rationale for therapy _____
 Current weight _____ kg/lbs Date recorded _____
 Height _____ in/cm BSA _____ m²
 NKDA Known drug allergies _____
 Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Cimzia® (certolizumab pegol)	<input type="checkbox"/> 200 mg prefilled syringe <input type="checkbox"/> 200 mg lyophilized powder vial (healthcare provider administration only)	Initial dose: <input type="checkbox"/> 400 mg (given as two 200 mg subcutaneous injections) at weeks 0, 2 and 4 <input type="checkbox"/> Other _____ Maintenance dose: <input type="checkbox"/> 400 mg subcutaneous injection every 4 weeks <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Humira® (adalimumab)	Initial dose: <input type="checkbox"/> 40 mg/0.8 mL pens starter package <input type="checkbox"/> 80 mg/0.8 mL citrate-free pens starter package <input type="checkbox"/> 80 mg/0.8 mL citrate-free prefilled syringe starter package <input type="checkbox"/> 80 mg/0.8 mL and 40 mg/0.4 mL citrate-free prefilled syringe starter package Maintenance dose: <input type="checkbox"/> 40 mg/0.4 mL citrate-free pen <input type="checkbox"/> 40 mg/0.4 mL citrate-free prefilled syringe <input type="checkbox"/> 40 mg/0.8 mL pen <input type="checkbox"/> 40 mg/0.8 mL prefilled syringe <input type="checkbox"/> 20 mg/0.2 mL citrate-free prefilled syringe <input type="checkbox"/> 20 mg/0.4 mL prefilled syringe	Initial dose: <input type="checkbox"/> Inject 160 mg subcutaneously on day 1, then 80 mg two weeks later (day 15), then two weeks later (day 29) 40 mg every other week <input type="checkbox"/> (Pediatric inflammatory bowel disease) Patient weight 17 kg to <40 kg, inject 80 mg subcutaneously on day 1, then 40 mg two weeks later (day 15), then two weeks later 20 mg every other week <input type="checkbox"/> (Pediatric inflammatory bowel disease) Patient weight >40 kg, inject 160 mg subcutaneously on day 1, then 80 mg two weeks later (day 15), then two weeks later (day 29) 40 mg every other week <input type="checkbox"/> Other _____ Maintenance dose: <input type="checkbox"/> 40 mg subcutaneous injection every other week <input type="checkbox"/> Other _____ Additional directions (cyclic, one-time, duration of therapy, etc.) _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Simponi® (golimumab)	<input type="checkbox"/> 100 mg prefilled syringe <input type="checkbox"/> 100 mg SmartJect® autoinjector	Initial dose: <input type="checkbox"/> 200 mg (given as two 100 mg subcutaneous injections) at week 0 <input type="checkbox"/> 100 mg subcutaneous injection at week 2 Maintenance dose: <input type="checkbox"/> 100 mg subcutaneous injection every 4 weeks <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Stelara® (ustekinumab)	<input type="checkbox"/> 45 mg/0.5 mL solution in a single-dose prefilled syringe <input type="checkbox"/> 90 mg/mL solution in a single-dose prefilled syringe	<input type="checkbox"/> Maintenance dose of 90 mg subcutaneous every 8 weeks (start 8 weeks after infused loading dose) <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> 2-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Tysabri® (natalizumab)	Tysabri® is available only through the TOUCH™ Prescribing Program. Please call 800.456.2255 or go to www.tysabri.com.		

Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy as needed
 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 inflammatory bowel disease team at 888.302.1028. To reach your team, call toll-free 844.516.3319.
 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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