Prescription & Enrollment Form

Inflammatory bowel disease—self-injectable

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: _____

Rationale for therapy _____

Current weight _____ kg/lbs Date recorded _____

Height _____ in/cm BSA _____ m^2

❑ NKDA ❑ Known drug allergies _____

_____

Concurrent meds _____

_____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
❑ Cimzia® (certolizumab pegol)	❑ 200 mg prefilled syringe ❑ 200 mg lyophilized powder vial (healthcare provider administration only)	**Initial dose:** ❑ 400 mg (given as two 200 mg subcutaneous injections) at weeks 0, 2 and 4 ❑ Other _____ **Maintenance dose:** ❑ 400 mg subcutaneous injection every 4 weeks ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Humira® (adalimumab)	**Initial dose:** ❑ 40 mg/0.8 mL pens starter package ❑ 80 mg/0.8 mL citrate-free pens starter package ❑ 80 mg/0.8 mL citrate-free prefilled syringe starter package ❑ 80 mg/0.8 mL and 40 mg/0.4 mL citrate-free prefilled syringe starter package **Maintenance dose:** ❑ 40 mg/0.4 mL citrate-free pen ❑ 40 mg/0.4 mL citrate-free prefilled syringe ❑ 40 mg/0.8 mL pen ❑ 40 mg/0.8 mL prefilled syringe ❑ 20 mg/0.2 mL citrate-free prefilled syringe ❑ 20 mg/0.4 mL prefilled syringe	**Initial dose:** ❑ 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 ❑ (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 ❑ (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 ❑ Other _____ **Maintenance dose:** ❑ 40 mg subcutaneous injection every other week ❑ Other _____ Additional directions (cyclic, one-time, duration of therapy, etc.) _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Simponi® (golimumab)	❑ 100 mg prefilled syringe ❑ 100 mg SmartJect® autoinjector	**Initial dose:** ❑ 200 mg (given as two 100 mg subcutaneous injections) at week 0 ❑ 100 mg subcutaneous injection at week 2 **Maintenance dose:** ❑ 100 mg subcutaneous injection every 4 weeks ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Stelara® (ustekinumab)	❑ 45 mg/0.5 mL solution in a single-dose prefilled syringe ❑ 90 mg/mL solution in a single-dose prefilled syringe	❑ Maintenance dose of 90 mg subcutaneous every 8 weeks (start 8 weeks after infused loading dose) ❑ Other _____	Dispense: ❑ 2-month supply ❑ Other _____ Refills _____
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.