Prescription & Enrollment Form

Inflammatory bowel disease—intravenous

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) _____

Cell phone _____ Other 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 _____ inches/cm BSA _____ m^2

❑ NKDA ❑ Known drug allergies _____

Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
❑ Entyvio® (vedolizumab)	300 mg single dose vial	❑ Infuse 300 mg intravenously at weeks 0, 2, 6 and then every 8 weeks thereafter. ❑ Infuse 300 mg intravenously every 8 weeks. Reconstitute each vial of Entyvio with 4.8 mL of sterile water and dilute in 250 mL of NS or sterile Lactated Ringer's. Infuse over 30 minutes.	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Remicade® (infliximab) ❑ Inflectra® (infliximab-dyyb) ❑ Renflexis® (infliximab-abda)	100 mg vial	**Loading dose:** ❑ None ❑ 5 mg/kg. Patient weight _____ (kg) = _____ mg IV at weeks 0, 2 and 6 ❑ Other _____ **Maintenance dose:** ❑ 5 mg/kg. Patient weight _____ (kg) = _____ mg IV every 8 weeks ❑ Other _____ Reconstitute each vial of Remicade with 10 mL of sterile water. Dilute desired dose in NS 250 mL to be infused over a period NOT less than 2 hours. Additional directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Stelara® (ustekinumab)	**Loading Dose** ❑ 130 mg/26 mL solution in a single dose vial **Maintenance Dose** ❑ 90 mg/mL solution in a single-dose prefilled syringe	**Loading Dose:** ❑ Infuse 260 mg intravenously at week 0 (55 kg or less). ❑ Infuse 390 mg intravenously at week 0 (85 kg > 55 kg). ❑ Infuse 520 mg intravenously at week 0 (> 85 kg). Dilute the desired dose in 250 mL of NS. Infuse over a period of at least 1 hour. **Maintenance Dose:** ❑ Inject 90 mg subcutaneously every 8 weeks (start 8 weeks after infused loading dose).	❑ 1-month supply ❑ 3-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.		
❑ Other _____			❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Other instructions			
❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy as needed.			Send quantity sufficient for medication days supply

Complete the below information if assistance from Accredo is requested in the coordination of your patient's infusion therapy.

Preferred infusion setting: ❑ Home ❑ Infusion clinic **Lab orders** _____

Premedication orders: ❑ Acetaminophen 650 mg PO 30 min prior to infusion ❑ Diphenhydramine 50 mg PO 30 min prior to infusion ❑ Hydrocortisone 100 mg IV PO 30 min prior to infusion
❑ Other _____ — Send quantity sufficient for medication days supply

Hypersensitivity/anaphylaxis orders: ❑ Stop infusion ❑ Start NS at TKO **For anaphylactic reaction, activate 911.** Notify physician of type reaction and action taken. Verbal report and transfer care to EMS, if applicable.

Medicate with: ❑ Epinephrine/EpiPen® 0.3 mg IM as needed for anaphylaxis ❑ Diphenhydramine 50 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if there is no IV access
❑ Hydrocortisone 100 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM in there is no IV access ❑ Solumedrol 125 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if there is no IV access — Send quantity sufficient for medication days supply

Flushing orders: ❑ Peripheral access ❑ Central venous access ❑ 0.9% sodium chloride flush with _____ mL IV before and after medication and IVP for maintenance
❑ Heparin _____ units per mL Flush with _____ units as final flush and as directed — Send quantity sufficient for medication days supply

❑ Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. Dispense 1 month of drug, flushes, needles, syringes, ancillary supplies and medical equipment necessary to establish access and administer medications. * If nursing services will be required for therapy administration, the home health nurse may call for additional orders per state regulations.

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.