# Deep vein thrombosis

**PRESCRIPTION & ENROLLMENT FORM**

accredo®
Specialty Pharmacy

**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 _____ 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:** _____
Patient weight _____ Date measured _____
**Laboratory results:**
Hematocrit _____% Date _____ Hemaglobin _____g/dl Date _____
Platelets _____ Date _____ CrCl _____mL/min 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 _____

**Please fax completed form to the Deep Vein Thrombosis team at 888.302.1028.**
To reach your team, call toll-free 888.608.9010.


DVT-00001-101515 amc6495

## 4 PRESCRIBING INFORMATION

| Medication | Strength / Formulation | Directions | Quantity/Refills |
|---|---|---|---|
| ❑ Arixtra® (fondaparinux sodium) | ❑ DVT/PE Treatment:<br>❑ 5 mg (wt<50 kg)<br>❑ 7.5 mg (wt 50–100 kg)<br>❑ 10 mg (wt>100 kg)<br>❑ Prophylaxis:<br>❑ 2.5 mg<br>❑ Other _____ | | Dispense:<br>❑ 1-month supply<br>❑ 3-month supply<br>❑ Other _____<br>Refills _____ |
| ❑ Fragmin® (dalteparin sodium) | ❑ DVT Prophylaxis:<br>❑ 2,500 units/mL prefilled syringe<br>❑ 5,000 units/mL prefilled syringe<br>❑ 10,000 units/mL prefilled syringe<br>❑ 12,500 units/mL prefilled syringe<br>❑ 15,000 units/mL prefilled syringe<br>❑ Other _____ | | Dispense:<br>❑ 1-month supply<br>❑ 3-month supply<br>❑ Other _____<br>Refills _____ |
| ❑ Lovenox® (enoxaparin sodium) | ❑ DVT Prophylaxis:<br>❑ 20 mg prefilled syringe<br>❑ 30 mg prefilled syringe<br>❑ 40 mg prefilled syringe<br>❑ Other _____<br>❑ DVT Treatment or unstable angina:<br>❑ 80 mg prefilled syringe<br>❑ 100 mg prefilled syringe<br>❑ 120 mg prefilled syringe<br>❑ Other _____ | ❑ Inject _____ mg subcutaneously daily<br>❑ Inject _____ mg subcutaneously twice daily<br>❑ Other _____ | Dispense:<br>❑ 1-month supply<br>❑ 3-month supply<br>❑ Other _____<br>Refills _____ |
| ❑ 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.

I authorize HUB to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

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.

**THIS AREA INTENTIONALLY LEFT BLANK.**