Prescription & Enrollment Form

Gilotrif® (afatinib)

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: _____

Current weight _____ kg/lbs Date wt obtained _____

❑ NKDA ❑ Known drug allergies _____

_____

Concurrent meds _____

_____

4 PRESCRIBING INFORMATION

The patient has tested positive for EGFR mutation: ❑ Yes ❑ No

The patient has squamous histology: ❑ Yes ❑ No

Medication	Strength/Formulation	Directions	Quantity/Refills
Gilotrif® (afatinib)	❑ 40 mg tablet ❑ 30 mg tablet ❑ 20 mg tablet	❑ Take _____ tablet(s) daily. ❑ Other _____ _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____

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

By your acknowledgement and signature above, an authorization is provided to dispense the prescription as written including a patient welcome kit with an associated supply of loperamide.

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 your drug therapy team at 888.454.8488.

To reach your team, call toll-free 844.569.2836.

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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