Prescription & Enrollment Form

HIV metabolic support

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name ______
Last name ______ Middle initial ____
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 copies of 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 first name ______ Last name ______
Prescriber's title ______
If NP or PA, under direction of Dr. ______
Office contact and title ______
Office contact e-mail ______
Office/clinic/institution name ______
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: B20 Human immunodeficiency virus [HIV] disease
❑ R64 Cachexia (Serostim® only) ❑ E88.1 Lipodystrophy (Egrifta® only)

Weight (kg) ______ Height (cm) ______ Date measured ______
BMI (kg/m²) ______ Blood fasting glucose (mg/dL) ______
Waist circumference (cm) ______ Hip circumference (cm) ______
Waist-to-hip ratio (waist-to-hip ratio = waist circumference ÷ hip circumference) ______
Injection training needed: ❑ Yes ❑ No By: ❑ MD office ❑ Other ______
If prior HgH use, date started ______
❑ NKDA ❑ Known drug allergies ______
Concurrent meds ______

Please attach the following information for growth disorder diagnosis:
Drug profile, labs, growth chart where applicable

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Egrifta® (tesamorelin)	1 mg vials and administration kit	❑ Inject 2 mg under the skin once daily ❑ Other ______	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
Egfrifta ancillary supplies: ❑ 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
❑ Serostim® (somatropin)	❑ 4 mg multi-dose vial (MDV) with bacteriostatic water for injection ❑ 5 mg single dose vial (SDV) with sterile water for injection ❑ 6 mg SDV with sterile water for injection ❑ Alternate 4 mg vial diluent: sterile water for injection (to use 4 mg vial as single use)	Inject ______ mg under the skin once daily at bedtime	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
Serostim ancillary supplies: Needle and Syringe: 3 cc syringe, with 20G, 1" needles for reconstitution And one of the following for injection: ❑ 27G, 1/2" needles ❑ 29G, 1/2" needles ❑ 30G, 1/2" needles			Send quantity sufficient for medication days supply
❑ Other ______			

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 also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

I certify that this medication is not being prescribed for anti-aging, cosmetic or athletic performance. I further certify human growth hormone is being prescribed for the medical condition noted above and 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 your endo team at 888.302.1028. To reach your team, call toll-free 844.516.3319.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

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