Prescription & Enrollment Form

Neutropenia

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) _____
Cell phone _____ Other 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: _____
Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic
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 location _____
Street address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____ PRIMARY DIAGNOSIS _____
Current weight _____kg/lbs Height _____inches/cm
BSA _____m^2 Date _____
Laboratory results:
WBC _____cell/mm^3 ANC _____cell/mm^3 Platelets _____cell/mm^3
Date _____ Date _____ Date _____
EXPECTED DATE OF FIRST/NEXT INJECTION _____
DATE OF LAST INJECTION (if applicable) _____
Agency nurse to visit home for injection: ❑ Yes ❑ No
Agency name and phone _____
❑ NKDA ❑ Known drug allergies _____
Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Granix® (tbo-filgrastim)	❑ 300mcg/0.5mL prefilled syringe ❑ 480mcg/0.8mL prefilled syringe	Inject _____mcg ❑ IV ❑ SC ❑ Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
❑ Leukine® (sargramostin) (liquid) ❑ Leukine® (lyophilized)	❑ 500mcg/mL ❑ 250mcg ❑ 500mcg	Inject _____mcg ❑ IV ❑ SC ❑ Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
❑ Neulasta® (pegfilgrastim) ❑ Fulphila® (pegfilgrastim-jmdb) ❑ Nyvepria™ (pegfilgrastim-apgf) ❑ Udenyca™ (pegfilgrastim-cbqv) ❑ Ziextenzo® (pegfilgrastim-bmez)	❑ 6mg/0.6mL prefilled syringe	Inject _____mg subcutaneously Dosing directions (include post chemo directions, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
❑ Neulasta® Onpro (pegfilgrastim)	❑ 6mg/0.6mL subcutaneous prefilled syringe kit	To be applied by health care professional. Inject 6mg under the skin every _____days as directed	Quantity _____ Days supply _____ Refills _____
❑ Neupogen® (filgrastim) ❑ Nivestym™ (filgrastim-aafi)	❑ 300mcg/mL vial ❑ 300mcg/0.5mL prefilled syringe ❑ 480mcg/1.6mL vial ❑ 480mcg/0.8mL prefilled syringe	Inject _____mcg ❑ IV ❑ SC ❑ Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
❑ Zarxio™ (filgrastim-sndz)	❑ 300mcg/0.5mL prefilled syringe ❑ 480mcg/0.8mL prefilled syringe	Inject _____mcg ❑ IV ❑ SC ❑ Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
❑ Other _____			
Supplies (if needed per dose): ❑ 1mL syringe ❑ 22G 1" mixing needle ❑ 25G 5/8" admin. needle ❑ 3mL syringe ❑ Sterile water 10mL ❑ 27 1/2G 5/8" admin. needle (pediatrics only)			Send quantity sufficient for medication days supply
❑ 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 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.

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.

Please fax completed form to the Neutropenia 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.