Psoriasis—intravenous 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: ______
Severity: ❑ Moderate ❑ Moderate to severe ❑ Severe ❑ BSA ______ %
Type: ❑ Plaque ❑ Other ______
Significant symptoms ______
Prior treatments: ❑ Topicals ❑ PUVA ❑ UVB ❑ Methotrexate ❑ Cyclosporine ❑ Oral retinoids
❑ Other ______
Medical justification for prescribing ______
❑ NKDA ❑ Known drug allergies ______
Concurrent meds ______

Please fax completed form to the Psoriasis team at 888.302.1028.
To reach your team, call toll-free 866.608.9010.

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4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
❑ Remicade® (infliximab)	❑ 100 mg vial	❑ New start dose ❑ 5 mg/kg. Patient weight ______ kg = ______ mg IV at weeks 0, 2, 6 ❑ Other ______ ❑ Continuing therapy dose ❑ 5 mg/kg. Patient weight ______ kg = ______ mg every 8 weeks ❑ Other ______ Reconstitute each vial of Remicade with 10 mL of sterile water. Dilute desired dose in normal saline 250 mL to be infused over a period NOT less than 2 hours. Additional directions (duration of therapy, etc.) ______ Expected date of first/next dose ______ Date of last dose ______	Dispense: ❑ 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 for administration	Send quantity sufficient for medication days supply
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 normal saline at TKO			Send quantity sufficient for medication days supply
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 no IV access. ❑ Hydrocortisone 100 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if no IV access. ❑ Solumedrol 125 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if no IV access.			Send quantity sufficient for medication days supply
For anaphylactic reaction, activate 911. Notify physician of type reaction and action taken. Verbal report and transfer care to EMS, if applicable.			
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
Lab orders ______ 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 medication.			

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.