RESET FORM

accredo®

Prescription Form

TO:
Accredo Health Group, Inc.
1620 Century Center Parkway
Memphis, TN 38134
Phone: 866.759.1557
Fax: Choose one:

Prescriber _____

Address _____

Phone _____ Fax _____

Faxed by: **Please fill out form completely and fax back to the number above.**

Patient ID # _____ Patient name _____

Date of birth _____ Phone _____

Active address _____

Drug and Non-drug Allergies _____

Patient weight (kg) _____ Date measured _____ Diagnosis code _____

Concurrent meds _____

Patient is currently receiving a: ❑ 1-month supply ❑ 3-month supply

Drug Name	Dose/Directions	Quantity and Refills
		Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills: _____
		Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ 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 Sig has changed, check the box below and indicate new directions. Otherwise, sign below to approve Sig as listed above.

❑ _____

Please sign on line below:

_____ _____ _____

Substitution allowed **Dispense as written** **Date**

Prescriber's full signature — signature required, no stamps. Prescriber certifies this is his/her full and usual signature.

Print prescriber's name: _____ If NP or PA, under direction of Dr. _____

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.

NPI #: _____ State license #: _____ (required for PA Medicaid)

DID YOU RECEIVE THIS FAX BY MISTAKE?

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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.

Return fax prepared by: _____ Date: _____

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