Prescription & Enrollment Form

accredo®

Rheumatoid arthritis—self-injectable

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: ______________________________
Pertinent medical history and clinical course ______________________________
____
Patient wt ____________ kg Date wt obtained ______________________
❑ NKDA ❑ Known drug allergies ______________________________
____
Concurrent meds ______________________________
____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
Actemra® (tocilizumab)	❑ 162 mg prefilled syringe	Inject 162 mg subcutaneously: ❑ Every other week ❑ Once per week ❑ Other ______________________	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ______
Cimzia® (certolizumab pegol)	Dispense: ❑ 200 mg prefilled syringe ❑ 200 mg lyophilized powder vial	Initial dose: ❑ 400 mg (given as two 200 mg subcutaneous injections) at weeks 0, 2, and 4 followed by: Maintenance dose: ❑ 200 mg subcutaneous injection every other week ❑ Other ______________________	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ______
Enbrel® (etanercept)	❑ 25 mg prefilled syringe ❑ 25 mg multiuse vial ❑ 50 mg prefilled syringe ❑ 50 mg Mini Cartridge ❑ 50 mg SureClick™	Inject subcutaneously: ❑ Once per week ❑ Twice per week (Juvenile arthritis) inject 0.8 mg/kg, maximum 50 mg/week Patient weight (kg) ________ Date obtained ____________	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ______
Humira® (adalimumab)	❑ 40 mg/0.4 mL citrate-free pen ❑ 40 mg/0.4 mL citrate-free prefilled syringe ❑ 40 mg/0.8 mL pen ❑ 40 mg/0.8 mL prefilled syringe ❑ 20 mg/0.2 mL citrate-free prefilled syringe ❑ 20 mg/0.4 mL prefilled syringe ❑ 10 mg/0.1 mL citrate-free prefilled syringe ❑ 10 mg/0.2 mL prefilled syringe	❑ Inject 40 mg subcutaneously every other week ❑ Inject 40 mg subcutaneously every week ❑ (Juvenile arthritis) Patient weight 10 kg to < 15 kg, inject 10 mg subcutaneously every other week ❑ (Juvenile arthritis) Patient weight 15 kg to < 30 kg, inject 20 mg subcutaneously every other week ❑ (Juvenile arthritis) Patient weight > 30 kg, inject 40 mg every other week Patient weight (kg) ________ Date obtained ____________	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ______
Kevzara® (sarilumab)	❑ 200 mg/1.14 mL prefilled pen ❑ 200 mg/1.14 mL prefilled syringe ❑ 150 mg/1.14 mL prefilled pen ❑ 150 mg/1.14 mL prefilled syringe	❑ 200 mg subcutaneous injection every two weeks ❑ 150 mg subcutaneous injection every two weeks ❑ Other ______________________	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ______
Orencia® (abatacept) Self-injection	❑ 125 mg/mL prefilled syringe ❑ 125 mg/mL ClickJect™ autoinjector	❑ Inject 125 mg subcutaneously once per week Loading dose: If intravenous loading dose desired, please also complete intravenous enrollment form	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ______
Simponi® (golimumab)	❑ 50 mg/0.5 mL SmartJect™ ❑ 50 mg/0.5 mL prefilled syringe	Inject 50 mg subcutaneously once per month	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ______
❑ Other ____________ ____________			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 shipped to physician's office, physician accepts on behalf of patient for administration in office.

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 the RA team at 888.302.1028. To reach your team, call toll-free 844.516.3319.

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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