Hyperparathyroidism

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: _____
Current weight _____ kg/lbs Date recorded _____
Laboratory results: iPTH _____ pg/mL Date _____ Calcium _____ mg/dL Date _____ Phosphorus _____ mg/dL Date _____
Agency nurse to visit home for injection: ❑ Yes ❑ No
Agency name & phone _____
❑ NKDA ❑ Known drug allergies _____
Concurrent meds _____

Please fax completed form to your team at 888.302.1028.
To reach your team, call toll-free 888.608.9010.

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
❑ Sensipar® (cinacalcet)	❑ 30 mg tablet ❑ 60 mg tablet ❑ 90 mg tablet	❑ Take _____ mg by mouth daily ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____

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.

PHYSICIAN SIGNATURE REQUIRED

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

_____ 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.

THIS AREA INTENTIONALLY LEFT BLANK.

HYP-00001-070615