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Prescription & Enrollment Form Crohn's Disease

accredo®

Four simple steps to submit your referral.

1 Patient Information



Please provide copies of front and back of all medical and prescription insurance cards.

New patient Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: Male Female Pronouns _____ Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: Patient's home Prescriber's office Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Has the patient been treated previously for this condition? Yes No

Is patient currently on therapy? Yes No Please list all therapies tried/failed: _____

Patient wt _____ Date wt obtained _____

NKDA Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Amjevita™ (adalimumab- atto) Citrate Free (ADULT)	40mg/0.8mL SureClick Autoinjector 40mg/0.8mL prefilled syringe (PFS)	Starter dose: Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1 month loading dose
		Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Other _____ Refills _____
Amjevita (adalimumab- atto) Citrate Free (PEDIATRIC) Patient weight is required for pediatric patients: _____ kg	40mg/0.8mL SureClick Autoinjector 40mg/0.8mL PFS	Starter dose: For 17kg to less than 40kg: Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 For 40kg or greater: Inject 160mg day 1 --OR-- Inject 80mg each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1 month loading dose
	20mg/0.4mL PFS	Maintenance dose: For 17kg to less than 40kg: Inject 20mg subcutaneously every other week	1-month supply 3-month supply Other _____ Refills _____
	40mg/0.8mL SureClick Autoinjector 40mg/0.8mL PFS	For 40kg or greater: Inject 40mg subcutaneously every other week	
Cimzia® (certolizumab)	Starter: 200mg/mL solution in a single-dose PFS Starter Kit 200mg/mL lyophilized powder in a single-dose vial for reconstitution	Inject 400mg subcutaneously at weeks 0, 2 and 4	1 STARTER KIT -OR- QS for full loading dose
	Maintenance: 200mg/mL solution in a single-dose prefilled syringe (PFS) 200mg/mL lyophilized powder in a single-dose vial for reconstitution	Inject 400mg subcutaneously every 4 weeks	1-month supply 3-month supply Other _____ Refills _____
Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

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

**SIGN
HERE**

_____ 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.

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Cyltezo® (adalimumab-adbm) Citrate Free (ADULT)	40mg/0.8mL pen 40mg/0.8mL PFS	Starter Dose: Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose
		Maintenance Dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Other _____ Refills _____
Cyltezo® (adalimumab-adbm) Citrate Free (PEDIATRIC) Patient weight is required for pediatric patients: _____ kg	40mg/0.8mL pen 40mg/0.8mL PFS	Starter Dose: For 17kg to less than 40kg: Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 For 40kg or greater: Inject 160mg day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	1 STARTER KIT -OR- QS for 1 month loading dose
	20mg/0.4mL PFS	Maintenance Dose: For 17kg to less than 40kg: Inject 20mg subcutaneously every other week For 40kg or greater: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Other _____ Refills _____
	40mg/0.8mL pen 40mg/0.8mL PFS		
Humira® (adalimumab) (ADULT)	Starter: 80mg/0.8mL prefilled pen Starter Package (3 PENS) 40mg /0.4mL prefilled syringes (PFS) for starter dose	160mg injected day 1 --OR-- 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1 STARTER KIT -OR- QS for 1 month loading dose
	Maintenance: 40mg/0.4mL citrate-free pen 40mg/0.8mL pen 40mg/0.4mL citrate-free PFS 40mg/0.8mL PFS	Inject 40mg subcutaneously every other week	1-month supply 3-month supply Other _____ Refills _____
Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
If shipped to physician's office, physician accepts on behalf of patient for administration in office.

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

**SIGN
HERE**

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.

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Humira® (adalimumab) (PEDIATRIC) Patient weight is required for pediatric patients: _____ kg	Starter: 80mg/0.8mL PFS Starter Package (3 syringes) 40mg /0.4mL PFS for starter dose	160mg injected day 1 --OR-- 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1 STARTER KIT -OR- QS for 1 month loading dose
	80mg/0.8mL and 40mg/0.4mL citrate-free SYRINGE starter package 40mg /0.4mL PFS for starter dose	80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29.	
	Maintenance: 40mg/0.4mL citrate-free pen 40mg/0.8mL PFS 40mg/0.4mL citrate-free PFS 80mg/0.8mL citrate-free pen 40mg/0.8mL pen 20mg/0.2mL PFS	Inject 40mg subcutaneously every other week Inject 20mg subcutaneously every other week	1-month supply 3-month supply Other _____ Refills _____
Stelara® (ustekinumab)	90mg/mL in each single-dose PFS	Maintenance: Inject 90mg subcutaneously every 8 weeks	2-month supply Other _____ Refills _____
		Maintenance Dose Only Needed. If loading dose is needed, please see IV referral form. By selecting Stelara on this form, I am indicating that patient has already received/does not need IV loading dose at this time.	
Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

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

**SIGN
HERE**

_____ Date Disperse 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.