

Please fax both pages of completed form to your team at 866.489.1901.

To reach your team, call toll-free 866.489.1899.

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Prescription & Enrollment Form Inflammatory Bowel 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 _____

Male Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail 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 _____

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 e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

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

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

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion clinic contact name _____ Phone _____ E-mail _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Rationale for therapy _____

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 _____ Height _____ in/cm BSA _____ m²

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	Dose	Directions	Quantity/Refills
Simponi® (golimumab)	100mg	Initial Dose: 200mg subcutaneously at week 0 followed by 100mg subcutaneously at 2 weeks Maintenance Dose: 100mg subcutaneously every 4 weeks	1-month supply 3-month supply Other _____ Refills _____
Xeljanz® (tofacitinib citrate)	5mg tablets 10mg tablets	Take 10mg by mouth twice daily for 8 weeks, followed by 5mg twice daily Take 10mg by mouth twice daily Take 5mg by mouth twice daily Take 5mg by mouth once daily	1-month supply 3-month supply Other _____ Refills _____
Other			
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			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 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.