Please fax both pages of completed form to your team at 888.302.1028.
To reach your team, call toll-free 844.516.3319.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Neutropenia

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 Preferred 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) ____ PRIMARY DIAGNOSIS ____

Current weight ____ kg/lbs Height ____ inches/cm BSA ____ m^2 Date measured ____

Laboratory results: WBC ____ cell/mm^3 ANC ____ cell/mm^3 Platelets ____ cell/mm^3

Date ____ Date ____ Date ____

EXPECTED DATE OF FIRST/NEXT INJECTION ____ DATE OF LAST INJECTION (if applicable) ____

Agency nurse to visit home for injection: Yes No

Agency name and phone ____

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
Granix® (tbo-filgrastim)	300mcg/mL vial 300mcg/0.5mL prefilled syringe 480mcg/1.6mL vial 480mcg/0.8mL prefilled syringe	Inject ______ mcg SC Other ______ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** ______	Quantity ______ Days supply ______ Refills ______
Leukine® (sargramostin) (liquid)	500mcg/mL vial	Inject ______ mcg IV SC Other ______ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** ______	Quantity ______ Days supply ______ Refills ______
Leukine® (lyophilized)	250mcg vial 500mcg vial		
Neulasta® (pegfilgrastim)	6mg/0.6mL prefilled syringe	Inject ______ mg subcutaneously Dosing directions (include post chemo directions, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** ______	Quantity ______ Days supply ______ Refills ______
Neulasta® Onpro (pegfilgrastim)	6mg/0.6mL subcutaneous prefilled syringe kit	To be applied by health care professional. Inject 6mg under the skin every ______ days as directed	Quantity ______ Days supply ______ Refills ______
Neupogen® (filgrastim) Nivestym™ (filgrastim-aafi)	300mcg/mL vial 300mcg/0.5mL prefilled syringe 480mcg/1.6mL vial 480mcg/0.8mL prefilled syringe	Inject ______ mcg IV SC Other ______ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** ______	Quantity ______ Days supply ______ Refills ______
Stimufend® (pegfilgrastim-fpgk)	6mg/0.6mL prefilled syringe	Inject ______ mg subcutaneously Dosing directions (include post chemo directions, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** ______	Quantity ______ Days supply ______ Refills ______
Zarxio™ (filgrastim-sndz)	300mcg/0.5mL prefilled syringe 480mcg/0.8mL prefilled syringe	Inject ______ mcg SC Other ______ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** ______	Quantity ______ Days supply ______ Refills ______
Other ______			
Supplies (if needed per dose): 1mL syringe 22G 1" mixing needle 25G 5/8" admin. needle 3mL syringe Sterile water 10mL 27 1/2G 5/8" admin. needle (pediatrics only)			Send quantity sufficient for medication days supply
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 or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

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.

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