Please fax both pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.412.4764.

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

Nourianz® (istradefylline)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's 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's first name _____ Last name _____

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

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/clinic/institution name _____ Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

3 Clinical Information

Primary ICD-10 code: _____ ☐ G20 Parkinson's Disease ☐ Other _____

Weight _____ kg/lbs Height _____ cm/in BSA _____ m^2 Date recorded _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Indicate current carbidopa/levodopa regimen: _____

Does patient have liver disease? ☐ No ☐ Yes (indicate Child-Pugh score and date calculated) _____ Date _____

Smoker? ☐ No ☐ Yes (indicate amount) _____ ***Note: Smoking in excess of 20 cigarettes per day may require dose increase (see package labeling).***

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
☐ Nourianz (istradefylline)	☐ 20mg tablets ☐ 40mg tablets	☐ Take one tablet by mouth once daily with or without food.	Dispense: ☐ 30-day supply ☐ 90-day supply ☐ Other Refills

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.

accredo®