**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

# Oncology (oral) (A-D)

accredo®

**Four simple steps to submit your referral.**

## 1 Patient Information

**Please provide 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 _____

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'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 _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

## 3 Clinical Information

**Primary ICD-10 code (REQUIRED):** _____

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

☐ 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 |
|---|---|---|---|
| ☐ abiraterone acetate | ☐ 250mg tablet<br>☐ 500mg tablet | ☐ Take 1000mg (four 250mg tablets or two 500mg tablets) orally once daily<br>☐ Other _____<br>If patient is NOT currently receiving prednisone, prescribe below in "Other." | Quantity _____<br>Days supply _____<br>Refills _____ |
| ☐ Afinitor® (everolimus) | ☐ 2.5mg tablet<br>☐ 5mg tablet<br>☐ 7.5mg tablet<br>☐ 10mg tablet | ☐ Take one tablet daily<br>☐ Other _____ | Quantity _____<br>Days supply _____<br>Refills _____ |
| ☐ Afinitor® **DISPERZ** (everolimus) | ☐ 2mg tablet<br>☐ 3mg tablet<br>☐ 5mg tablet | ☐ Dissolve _____ tablet(s) in water and drink daily<br>☐ Other _____ | Quantity _____<br>Days supply _____<br>Refills _____ |
| ☐ Other | | | Quantity _____<br>Days supply _____<br>Refills _____ |
| ☐ Other | | | Quantity _____<br>Days supply _____<br>Refills _____ |

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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