

Please fax all 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](https://myaccredopatients.com) to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Anzupgo® (delgocitinib)

EVERNORTH
HEALTH SERVICES

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 _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: Male Female Gender identity _____ 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 _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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 _____

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

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Weight (kg) _____ Height (cm) _____ Date measured _____

NKDA Known drug allergies _____

Prior therapies (include start and stop dates) _____

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 |
|----------------------------|----------------------|---|---|
| Anzupgo® (delgocitinib) | 2% cream, 30g | Apply a thin layer twice daily to clean and dry skin of the affected areas only on the hands and wrists. Do not use more than 30g per 2 weeks or 60g per month. | Quantity (# of tubes) _____ Refills _____ |
| Other _____ | | | 1-month supply 3-month supply Other _____ Refills _____ |

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.