Please fax both pages of completed form to your team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
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

Arthritis and Inflammatory—Intravenous

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813 5412

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 ______ 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 ______

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 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 dotted line:

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

Site street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion site contact ______ Phone ______ Fax ______ E-mail ______

3 Clinical Information

Primary ICD-10 code (REQUIRED): ______

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 ______

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	Fluids for administration and reconstitution (please strike through if not required)	Quantity/Refills
Actemra® (tocilizumab)	Rheumatoid Arthritis (RA): 4mg/kg intravenous infusion every 4 weeks. Maximum dose of 800mg/infusion 8mg/kg intravenous infusion every 4 weeks. Maximum dose of 800mg/infusion Polyarticular Juvenile Idiopathic Arthritis (PJIA): 10mg/kg intravenous infusion every 4 weeks (2 years or older, Less than 30kg) 8mg/kg intravenous infusion every 4 weeks (2 years or older, 30kg or greater) Systemic Juvenile Idiopathic Arthritis (SJIA) and Cytokine Release Syndrome: 12mg/kg intravenous infusion every 2 weeks (2 years or older, Less than 30kg) Maximum dose of 800mg/infusion 8mg/kg intravenous infusion every 2 weeks (2 years or older, 30kg or greater) Maximum dose of 800mg/infusion	Dilute desired dose with normal saline to total desired volume to be infused over 1 hour. NS 0.9% 100mL >30kg NS 0.9% 50mL < 30kg	Dispense 1-month supply. Refill x 1 year unless noted otherwise. Dispense 90-day supply. Refill x 1 year unless noted otherwise. Other ______ Refills ______
Orencia® (abatacept)	Rheumatoid Arthritis and Psoriatic Arthritis: 500mg (less than 60kg) intravenous infusion 750mg (60 to 100kg) intravenous infusion 1000mg (over 100kg) intravenous infusion Juvenile Idiopathic Arthritis: 10mg/kg intravenous infusion (if less than 75kg) 750mg intravenous infusion (75 to 100kg) 1,000mg intravenous infusion (over 100kg) **Starting dose:** at week: 0, 2 and 4, then every 4 weeks	Reconstitute each vial of Orencia with 10mL of sterile water. Dilute desired dose to total of 100mL in normal saline to be infused over 30 minutes. NS 0.9% 100mL Sterile Water as needed for reconstitution.	**Starter dose:** x 3 doses. No refills.
	Maintenance dose: every 4 weeks		**Maintenance dose:** 1-month supply Refill x 1 year unless noted otherwise Other ______ Refills ______
Simponi Aria® (golimumab)	**Starting dose:** 2mg/kg ______ mg IV at week: 0, 4 and every 8 weeks Other ______	Dilute desired dose with normal saline to a total volume of 100mL to be infused over 30 minutes.	**Starter dose:** x 3 doses. No refills.
	Maintenance dose: 2mg/kg ______ mg IV every 8 weeks Other ______		**Maintenance dose:** 1-month supply Refill x 1 year unless noted otherwise Other ______ Refills ______
Other			Other ______ 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.

Patient's first name ______________ Last name ______________ Middle initial ____ Date of birth __________

Prescriber's first name ______________ Last name ______________ Phone ______________

4 Prescribing Information

Complete the below information if assistance from Accredo is requested in the coordination of your patient's infusion therapy.

Preferred infusion setting: Home Infusion clinic

Premedication orders Acetaminophen 650mg PO 30 min prior to infusion
Diphenhydramine 50mg PO 30 min prior to infusion Hydrocortisone 100mg IVP 30 min prior to infusion
Other ______________

Send quantity and refills sufficient for medication days supply.

Infusion method: Gravity (Pediatric patients will be given a pump unless noted otherwise)

Flushing orders NS 0.9% Flush (if central venous access, sterile flush will be provided)
Choose administration access: Peripheral access Central venous access

If central venous access: Flush with 10mL Sterile NS 0.9% before and after infusion. Follow with heparin 100units/mL 5mL final flush

If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed

Hypersensitivity/Anaphylaxis

Stop infusion

Medicate with:

Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis (for children less than 30kg: Epinephrine 0.15mg)

Start NS 0.9% 100mL at TKO Diphenhydramine 50mg slow IVP PRN anaphylaxis
Hydrocortisone 100mg slow IVP PRN anaphylaxis
Methylprednisolone 125mg slow IVP PRN anaphylaxis Diphenhydramine 50mg PO PRN anaphylaxis
Other ______________

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. *If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

Lab orders ______________

Frequency ______________

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

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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