

Please fax all 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 Crohn's Disease—Humira and Biosimilars

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 _____

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 _____

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): _____ 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	Strength/Formulation	Directions	Quantity/Refills
adalimumab-aacf Citrate Free Patient weight is requested for pediatric patients: _____ kg	40mg/0.8mL pen	For Adults and Children 6 yrs and older weighing 40kg (88 lbs) and greater: Loading dose: Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		For Adults and Children 6 yrs and older weighing 40kg (88 lbs) and greater: Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Amjevita™ (adalimumab-atto) Citrate Free (ADULT)	40mg/0.8mL SureClick Autoinjector 40mg/0.8mL prefilled syringe (PFS) 40mg/0.4mL PFS SureClick Autoinjector	Loading dose: Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Amjevita™ (adalimumab-atto) Citrate Free (PEDIATRIC) Patient weight is required for pediatric patients: _____ kg	40mg/0.8mL SureClick Autoinjector 40mg/0.8mL PFS 40mg/0.4mL PFS SureClick Autoinjector	Loading dose: For 17kg to less than 40kg: Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 For 40kg or greater: Inject 160mg day 1 --OR-- Inject 80mg each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: For 17kg to less than 40kg: Inject 20mg subcutaneously every other week For 40kg or greater: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
		20mg/0.4mL PFS 20mg/0.2mL PFS 40mg/0.8mL SureClick Autoinjector 40mg/0.8mL PFS 40mg/0.4mL PFS 40mg/0.4mL SureClick Autoinjector	
Other			

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

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
Cyltezo® (adalimumab-adbm) Citrate Free (ADULT)	40mg/0.8mL pen 40mg/0.8mL PFS	Loading dose: Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Cyltezo® (adalimumab-adbm) Citrate Free (PEDIATRIC) Patient weight is required for pediatric patients: _____ kg	40mg/0.8mL pen 40mg/0.8mL PFS	Loading dose: For 17kg to less than 40kg: Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 For 40kg or greater: Inject 160mg day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	1 starter kit -OR- QS for 1-month loading dose No Refills
	20mg/0.4mL PFS	Maintenance Dose: For 17kg to less than 40kg: Inject 20mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
	40mg/0.8mL pen 40mg/0.8mL PFS	For 40kg or greater: Inject 40mg subcutaneously every other week	
adalimumab-adbm Citrate Free (ADULT)	40mg/0.8mL pen 40mg/0.8mL PFS	Loading dose: For 17kg to less than 40kg: Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 For 40kg or greater: Inject 160mg day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: For 17kg to less than 40kg: Inject 20mg subcutaneously every other week For 40kg or greater: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Other			

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

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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
Hadlima™ (adalimumab- bwwd) Citrate Free (ADULT)	40mg/0.8mL PFS 40mg/0.4mL PFS 40mg/0.8mL PushTouch Autoinjector 40mg/0.4mL PushTouch Autoinjector	Loading dose: Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Humira® (adalimumab) (ADULT)	Starter: 80mg/0.8mL prefilled pen Starter Package (3 pens) 40mg/0.4mL PFS for starter dose	Loading dose: 160mg injected day 1 --OR-- 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1 starter kit -OR- QS for 1-month loading dose No Refills
	Maintenance: 40mg/0.4mL citrate-free pen 40mg/0.8mL pen 40mg/0.4mL citrate-free PFS 40mg/0.8mL PFS	Maintenance Dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Idacio® (adalimumab- aacf) Citrate Free Patient weight is requested for pediatric patients: _____ kg	40mg/0.8mL PFS 40mg/0.8mL Pen	For Adults and Children 6 yrs and older weighing 40kg (88 lbs) and greater: Loading dose: Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		For Adults and Children 6 yrs and older weighing 40kg (88 lbs) and greater: Maintenance Dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Other			

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

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 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

Medication	Strength/Formulation	Directions	Quantity/Refills
Humira® (adalimumab) (PEDIATRIC) Patient weight is required for pediatric patients: _____ kg	Starter: 40mg/0.4mL PFS for starter dose	Loading dose: 160mg injected day 1 --OR-- 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1 starter kit -OR- QS for 1-month loading dose No Refills
	40mg/0.4mL PFS for starter dose	Loading dose: 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29.	
	Maintenance: 40mg/0.4mL citrate-free pen 40mg/0.4mL citrate-free PFS 40mg/0.8mL pen 40mg/0.8mL PFS 80mg/0.8mL citrate-free pen 20mg/0.2mL PFS	Maintenance Dose: Inject 40mg subcutaneously every other week Inject 20mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Hyrimoz® (adalimumab-adaz) Citrate Free (ADULT)	80mg/0.8mL Pen Starter Pack (3 pens)	Loading dose: Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
	40mg/0.4mL pen 40mg/0.4mL PFS	Maintenance Dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
adalimumab-adaz Citrate Free (ADULT)	40mg/0.4mL pen 40mg/0.4mL PFS	Loading dose: Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Other			

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SIGN HERE

_____ Date Disperse as written Date Substitution allowed

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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
Hyrimoz® (adalimumab-adaz) Citrate Free (PEDIATRIC) Patient weight is required for pediatric patients: _____ kg	80mg/0.8mL and 40mg/0.4mL PFS Pediatric Crohn's Starter Pack (2 PFS)	Loading dose: For 17kg to less than 40kg: Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 For 40kg or greater: Inject 160mg on day 1 --OR-- Inject 80mg each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
	20mg/0.2mL PFS 40mg/0.4mL PFS 40mg/0.4mL pen	Maintenance Dose: For 17kg to less than 40kg: Inject 20mg subcutaneously every other week For 40kg or greater: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
adalimumab-adaz Citrate Free (PEDIATRIC) Patient weight is required for pediatric patients: _____ kg	40mg/0.4mL PFS 40mg/0.4mL pen	Loading dose: For 17kg to less than 40kg: Inject 80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29 For 40kg or greater: Inject 160mg on day 1 --OR-- Inject 80mg each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: For 17kg to less than 40kg: Inject 20mg subcutaneously every other week For 40kg or greater: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Other			

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**SIGN
HERE**

Date

Dispense as written

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