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
Crohn's Disease

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 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
☐ Amjevita™ (adalimumab-atto) Citrate Free **(ADULT)**	☐ 40mg/0.8mL SureClick Autoinjector ☐ 40mg/0.8mL prefilled syringe (PFS)	**Starter 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
		Maintenance dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Other _____ ☐ Refills _____
☐ Amjevita (adalimumab-atto) Citrate Free **(PEDIATRIC)** Patient weight is required for pediatric patients: _____ kg	☐ 40mg/0.8mL SureClick Autoinjector ☐ 40mg/0.8mL PFS	**Starter 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
	☐ 20mg/0.4mL PFS	**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 ☐ Other _____ ☐ Refills _____
	☐ 40mg/0.8mL SureClick Autoinjector ☐ 40mg/0.8mL PFS		
☐ Cimzia® (certolizumab)	**Starter**: ☐ 200mg/mL solution in a single-dose PFS Starter Kit ☐ 200mg/mL lyophilized powder in a single-dose vial for reconstitution	Inject 400mg subcutaneously at weeks 0, 2 and 4	1 STARTER KIT -OR- QS for full loading dose
	Maintenance: ☐ 200mg/mL solution in a single-dose prefilled syringe (PFS) ☐ 200mg/mL lyophilized powder in a single-dose vial for reconstitution	Inject 400mg subcutaneously every 4 weeks	☐ 1-month supply ☐ 3-month supply ☐ Other _____ ☐ Refills _____
☐ 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	**Starter 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
		Maintenance Dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Other _____ ☐ Refills _____
☐ Cyltezo® (adalimumab-adbm) Citrate Free (PEDIATRIC) Patient weight is required for pediatric patients: _____ kg	☐ 40mg/0.8mL pen ☐ 40mg/0.8mL PFS	**Starter 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
	☐ 20mg/0.4mL PFS ☐ 40mg/0.8mL pen ☐ 40mg/0.8mL PFS	**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 ☐ Other _____ ☐ Refills _____
☐ Humira® (adalimumab) (ADULT)	**Starter:** ☐ 80mg/0.8mL prefilled pen Starter Package (3 PENS) ☐ 40mg /0.4mL prefilled syringes (PFS) for starter 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
	Maintenance: ☐ 40mg/0.4mL citrate-free pen ☐ 40mg/0.8mL pen ☐ 40mg/0.4mL citrate-free PFS ☐ 40mg/0.8mL PFS	Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Other _____ ☐ Refills _____
☐ 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
☐ Humira® (adalimumab) (PEDIATRIC) Patient weight is required for pediatric patients: _____ kg	**Starter**: ☐ 80mg/0.8mL PFS Starter Package (3 syringes) ☐ 40mg /0.4mL PFS for starter 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
	☐ 80mg/0.8mL and 40mg/0.4mL citrate-free SYRINGE starter package ☐ 40mg /0.4mL PFS for starter 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/0.8mL PFS ☐ 40mg/0.4mL citrate-free PFS ☐ 80mg/0.8mL citrate-free pen ☐ 40mg/0.8mL pen ☐ 20mg/0.2mL PFS	☐ Inject 40mg subcutaneously every other week ☐ Inject 20mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Other _____ ☐ Refills _____
☐ Stelara® (ustekinumab)	☐ 90mg/mL in each single-dose PFS	**Maintenance**: ☐ Inject 90mg subcutaneously every 8 weeks	☐ 2-month supply ☐ Other _____ ☐ Refills _____
		Maintenance Dose Only Needed. If loading dose is needed, please see IV referral form. By selecting Stelara on this form, I am indicating that patient has already received/does not need IV loading dose at this time.	
☐ 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.

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