

Prescription & Enrollment Form
Deep vein thrombosis



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

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

1 PATIENT INFORMATION

New patient Current

Patient's first name _____
 Last name _____ Middle initial _____
 Date of birth _____ Male Female Last 4 digits of SSN _____
 Street address _____ Apt # _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____
 Home phone _____
 Work phone _____
 Cell phone _____
 Evening phone _____
 E-mail address _____
 Patient's primary language: English Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____
 Phone _____
 Insured's name _____
 Insured's employer _____ Relationship to patient _____
 Identification # _____ Policy/group # _____
 Prescription card: Yes No If yes, carrier _____
 Policy # _____ Group # _____
 Is patient eligible for Medicare? Yes No
 Does patient have a secondary insurance? Yes No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
 Prescriber's first name _____ Last name _____
 Prescriber's title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 Office contact e-mail _____
 Office/clinic/institution name _____
 Clinic/hospital affiliation _____
 Street address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI # _____ License # _____
 Deliver product to: Office Patient's home Clinic
 Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
 Patient weight _____ Date measured _____
Laboratory results:
 Hematocrit _____ % Date _____ Hemoglobin _____ g/dl Date _____
 Platelets _____ Date _____ CrCl _____ mL/min Date _____
 EXPECTED DATE OF FIRST/NEXT INJECTION _____
 DATE OF LAST INJECTION (if applicable) _____
 Agency nurse to visit home for injection: Yes No
 Agency name & phone _____
 NKDA Known drug allergies _____
 Concurrent meds _____

4 PRESCRIBING INFORMATION

| Medication | Strength/Formulation | Directions | Quantity/Refills |
|--|---|--|--|
| <input type="checkbox"/> Arixtra® (fondaparinux sodium) | <input type="checkbox"/> DVT/PE Treatment: <input type="checkbox"/> 5 mg (wt<50 kg) <input type="checkbox"/> 7.5 mg (wt 50-100 kg) <input type="checkbox"/> 10 mg (wt>100 kg) <input type="checkbox"/> Prophylaxis: <input type="checkbox"/> 2.5 mg <input type="checkbox"/> Other _____ | | Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____ |
| <input type="checkbox"/> Fragmin® (dalteparin sodium) | <input type="checkbox"/> DVT Prophylaxis: <input type="checkbox"/> 2,500 units/mL prefilled syringe <input type="checkbox"/> 5,000 units/mL prefilled syringe <input type="checkbox"/> 10,000 units/mL prefilled syringe <input type="checkbox"/> 12,500 units/mL prefilled syringe <input type="checkbox"/> 15,000 units/mL prefilled syringe <input type="checkbox"/> Other _____ | | Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____ |
| <input type="checkbox"/> Lovenox® (enoxaparin sodium) | <input type="checkbox"/> DVT Prophylaxis: <input type="checkbox"/> 20 mg prefilled syringe <input type="checkbox"/> 30 mg prefilled syringe <input type="checkbox"/> 40 mg prefilled syringe <input type="checkbox"/> Other _____ <input type="checkbox"/> DVT Treatment or unstable angina: <input type="checkbox"/> 80 mg prefilled syringe <input type="checkbox"/> 100 mg prefilled syringe <input type="checkbox"/> 120 mg prefilled syringe <input type="checkbox"/> Other _____ | <input type="checkbox"/> Inject _____ mg subcutaneously daily <input type="checkbox"/> Inject _____ mg subcutaneously twice daily <input type="checkbox"/> Other _____ | Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____ |
| <input type="checkbox"/> Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy as needed for administration | | | Send quantity sufficient for medication days supply |

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

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.

Please fax completed form to your drug therapy 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.

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