Prescription & Enrollment Form

Deep vein thrombosis

Four simple steps to submit your referral.

accredo®

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

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 _____ Hemaglobin _____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
❑ Arixtra® (fondaparinux sodium)	❑ DVT/PE Treatment: ❑ 5 mg (wt<50 kg) ❑ 7.5 mg (wt 50–100 kg) ❑ 10 mg (wt>100 kg) ❑ Prophylaxis: ❑ 2.5 mg ❑ Other _____		Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Fragmin® (dalteparin sodium)	❑ DVT Prophylaxis: ❑ 2,500 units/mL prefilled syringe ❑ 5,000 units/mL prefilled syringe ❑ 10,000 units/mL prefilled syringe ❑ 12,500 units/mL prefilled syringe ❑ 15,000 units/mL prefilled syringe ❑ Other _____		Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Lovenox® (enoxaparin sodium)	❑ DVT Prophylaxis: ❑ 20 mg prefilled syringe ❑ 30 mg prefilled syringe ❑ 40 mg prefilled syringe ❑ Other _____ ❑ DVT Treatment or unstable angina: ❑ 80 mg prefilled syringe ❑ 100 mg prefilled syringe ❑ 120 mg prefilled syringe ❑ Other _____	❑ Inject _____ mg subcutaneously daily ❑ Inject _____ mg subcutaneously twice daily ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ 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.