Prescription & Enrollment Form

HIV metabolic support

accredo®
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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: B20 Human immunodeficiency virus [HIV] disease
❑ R64 Cachexia (Serostim® only) ❑ E88.1 Lipodystrophy (Egrifta® only)

Weight (kg) _____ Height (cm) _____ Date measured _____
BMI (kg/m²) _____ Blood fasting glucose (mg/dL) _____
Waist circumference (cm) _____ Hip circumference (cm) _____
Waist-to-hip ratio (waist-to-hip ratio = waist circumference ÷ hip circumference) _____
Injection training needed: ❑ Yes ❑ No By: ❑ MD office ❑ Other _____
If prior HgH use, date started _____
❑ NKDA ❑ Known drug allergies _____
Concurrent meds _____

Please attach the following information for growth disorder diagnosis:
Drug profile, labs, growth chart where applicable

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Egrifta® (tesamorelin)	1 mg vials and administration kit	❑ Inject 2 mg under the skin once daily ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
Egfrifta ancillary supplies: ❑ 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
❑ Serostim® (somatropin)	❑ 4 mg multi-dose vial (MDV) with bacteriostatic water for injection ❑ 5 mg single dose vial (SDV) with sterile water for injection ❑ 6 mg SDV with sterile water for injection ❑ Alternate 4 mg vial diluent: sterile water for injection (to use 4 mg vial as single use)	Inject _____ mg under the skin once daily at bedtime	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
Serostim ancillary supplies: Needle and Syringe: 3 cc syringe, with 20G, 1" needles for reconstitution And one of the following for injection: ❑ 27G, 1/2" needles ❑ 29G, 1/2" needles ❑ 30G, 1/2" needles			Send quantity sufficient for medication days supply
❑ Other _____			

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.

I certify that this medication is not being prescribed for anti-aging, cosmetic or athletic performance. I further certify human growth hormone is being prescribed for the medical condition noted above and is medically necessary.

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 endo 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.