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

Neutropenia

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 Preferred 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) ______ PRIMARY DIAGNOSIS ______

Current weight ______ kg/lbs Height ______ inches/cm BSA ______ m^2 Date measured ______

Laboratory results: WBC ______ $cell/mm^3$ ANC ______ $cell/mm^3$ Platelets ______ $cell/mm^3$

Date ______ Date ______ Date ______

EXPECTED DATE OF FIRST/NEXT INJECTION ______ DATE OF LAST INJECTION (if applicable) ______

Agency nurse to visit home for injection: ☐ Yes ☐ No

Agency name and phone ______

☐ 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
☐ Granix® (tbo-filgrastim)	☐ 300mcg/mL vial ☐ 300mcg/0.5mL prefilled syringe ☐ 480mcg/1.6mL vial ☐ 480mcg/0.8mL prefilled syringe	Inject _____ mcg ☐ SC ☐ Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
☐ Leukine® (sargramostin) (liquid)	☐ 500mcg/mL vial	Inject _____ mcg ☐ IV ☐ SC ☐ Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
☐ Leukine® (lyophilized)	☐ 250mcg vial ☐ 500mcg vial		
☐ Neulasta® (pegfilgrastim)	☐ 6mg/0.6mL prefilled syringe	Inject _____ mg subcutaneously Dosing directions (include post chemo directions, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
☐ Neulasta® Onpro (pegfilgrastim)	☐ 6mg/0.6mL subcutaneous prefilled syringe kit	To be applied by health care professional. Inject 6mg under the skin every _____ days as directed	Quantity _____ Days supply _____ Refills _____
☐ Neupogen® (filgrastim)	☐ 300mcg/mL vial ☐ 300mcg/0.5mL prefilled syringe ☐ 480mcg/1.6mL vial ☐ 480mcg/0.8mL prefilled syringe	Inject _____ mcg ☐ IV ☐ SC ☐ Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
☐ Nivestym™ (filgrastim-aafi)			
☐ Stimufend® (pegfilgrastim-fpgk)	☐ 6mg/0.6mL prefilled syringe	Inject _____ mg subcutaneously Dosing directions (include post chemo directions, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
☐ Zarxio™ (filgrastim-sndz)	☐ 300mcg/0.5mL prefilled syringe ☐ 480mcg/0.8mL prefilled syringe	Inject _____ mcg ☐ SC ☐ Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) **Please include cycle.** _____	Quantity _____ Days supply _____ Refills _____
☐ Other _____			
Supplies (if needed per dose): ☐ 1mL syringe ☐ 22G 1" mixing needle ☐ 25G 5/8" admin. needle ☐ 3mL syringe ☐ Sterile water 10mL ☐ 27 1/2G 5/8" admin. needle (pediatrics only)			Send quantity sufficient for medication days supply
☐ 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 or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

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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