Please fax all pages of completed form to your team at 888.302.1028.
To reach your team, call toll-free 844.516.3319.
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
Nulojix®

accredo®

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 _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ 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 _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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

INFUSION LOCATION: ☐ Patient's home ☐ Healthcare facility

Medication	Strength/Formulation	Directions	Quantity/Refills	Ship to
Nulojix®	250mg vial The total infusion dose of Nulojix should be based on the actual body weight of the patient at the time of transplantation and should not be modified during the course of therapy, unless there is a change in body weight of greater than 10%. Date of Transplant: _____ Weight at time of transplant: _____ Current Weight: _____	All doses must be divisible by 12.5mg ☐ **Initial Phase Dosing (post-transplant):** Infuse 10mg/kg (_____mg) intravenously at the end of weeks 2, 4, 8, 12. ☐ Patient does not need initial phase dosing If patient needs partial initial phase dosing, indicate what is needed: ☐ End of weeks 4, 8, 12 ☐ End of weeks 8, 12 ☐ End of week 12 only **OR** ☐ **Alternate Initial Phase Dosing (post-transplant):** Infuse _____mg/kg (_____mg) intravenously every _____ weeks for a total of _____ doses to complete the initial phase. Clinical Rationale for alternate dosing: _____	Dispense: QS for initial phase dosing No Refills ☐ Other Qty _____ ☐ Other Refills _____	**The initial phase dosing must be administered in a controlled setting.** **Please check one:** ☐ MDO ☐ Infusion Clinic ☐ Unknown
		☐ **Maintenance Phase Dosing (post-transplant):** Infuse 5mg/kg (_____mg) intravenously at the end of week 16 and every 4 weeks thereafter. **OR** ☐ **Alternate Maintenance Phase Dosing (post-transplant):** Infuse _____mg/kg (_____mg) intravenously every _____ weeks. Clinical Rationale for alternate dosing: _____	Dispense: 28-day supply Refill x 1 year unless noted otherwise. ☐ Other Qty _____ ☐ Other Refills _____	**Please check one:** ☐ Home ☐ MDO ☐ Infusion Clinic ☐ Unknown

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

Required medication and supplies for home infusion (please complete this section for home infusions only)

Send quantity and refills sufficient for medication dosing and days supply.

Premedication orders:

☐ _____

Infusion method: Gravity unless otherwise instructed (☐ Prefer Pump)

Fluids for administration and reconstitution (please strike through if not required)

Sterile Water as needed for reconstitution

NS 0.9% 100mL

NS 0.9% Flush (if central venous access, sterile flush will be provided)

All Nulojix orders will be administered via peripheral line unless otherwise noted.

Choose administration access: ☐ Peripheral access ☐ Central venous access

If central venous access: Flush with 10mL Sterile NS 0.9% before and after infusion. ☐ Follow with heparin 100units/mL 5mL final flush

If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed

Hypersensitivity/Anaphylaxis

Stop infusion

Medicate with:

Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis

☐ Diphenhydramine 50mg PO PRN anaphylaxis

☐ Other _____

☐ Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. *If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

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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