

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
Oncology (oral) (E-S)

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'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 _____

Deliver product to: Prescriber's office Patient's home

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____

Weight _____ kg/lbs Height _____ cm/in BSA _____ m² Date recorded _____

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
Erleada® (apalutamide)	60mg tablets 240mg tablet	240mg (four 60mg tablets) orally once daily 240mg (1 tablet) orally once daily	Quantity _____ Days supply _____ Refills _____
Lorbrena® (lorlatinib)	25mg tablet 100mg tablet	Take _____ mg orally twice daily Other _____	Quantity _____ Days supply _____ Refills _____
Promacta® (eltrombopag)	12.5mg tablet 25mg tablet 50mg tablet 75mg tablet	Take _____ tablet(s) orally twice daily Other _____	Quantity _____ Days supply _____ Refills _____
Sprycel® (dasatinib)	20mg tablet 50mg tablet 70mg tablet 80mg tablet 100mg tablet 140mg tablet	Take one tablet orally daily Other _____	Quantity _____ Days supply _____ Refills _____
Sutent® (sunitinib malate)	12.5mg capsule 25mg capsule 37.5mg capsule 50mg capsule	Take one capsule orally daily continuously Take _____ capsule(s) orally daily 4 weeks on and 2 weeks off Other _____	Quantity _____ Days supply _____ Refills _____
Other _____	_____	_____	Quantity _____ Days supply _____ Refills _____
Other _____	_____	_____	Quantity _____ Days supply _____ Refills _____

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