Please fax all 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 REMS

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 the patient's 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: 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'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): _____
Current weight _____ kg/lbs Height _____ inches/cm
BSA _____ m^2 Date obtained _____
Patient type from PPAF (check one): ☐ Adult Male ☐ Male Child ☐ Adult Female – NOT of Reproductive Potential
☐ 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
☐ Pomalyst® (pomalidomide)	☐ 1mg capsule ☐ 2mg capsule ☐ 3mg capsule ☐ 4mg capsule	☐ Take _____capsule(s) daily ☐ Take _____capsule(s) for _____days on and _____days off --- **For Multiple Myeloma**: The recommended starting dose of Pomalyst is 4mg/day orally for Days 1 – 21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings. **Authorization #** _____ **Date** _____ **(To be filled in by healthcare provider)** **Patient type from PPAF (check one): ☐ Adult Male ☐ Male Child ☐ Adult Female – NOT of Reproductive Potential ☐ Adult Female – Reproductive Potential ☐ Female Child – NOT of Reproductive Potential ☐ Female Child – Reproductive Potential**	Quantity _____ No refills **For Kaposi Sarcoma (KS):** The recommended starting dose of Pomalyst is 5mg/day orally for Days 1-21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings.
☐ Revlimid® (lenalidomide)	☐ 2.5mg capsule ☐ 5mg capsule ☐ 10mg capsule ☐ 15mg capsule ☐ 20mg capsule ☐ 25mg capsule	☐ Take _____capsule(s) daily ☐ Take _____capsule(s) for _____days on and _____days off --- **Myelodysplastic Syndromes and Multiple Myeloma maintenance following autologous hematopoietic stem cell transplantation:** The recommended starting dose of Revlimid is 10mg/day with water. Dosing is continued or modified based upon clinical and laboratory findings. **Multiple Myeloma and Mantle Cell Lymphoma:** The recommended starting dose of Revlimid is 25mg/day orally for Days 1 – 21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings. **Authorization #** _____ **Date** _____ **(To be filled in by healthcare provider)** **Patient type from PPAF (check one): ☐ Adult Male ☐ Male Child ☐ Adult Female – NOT of Reproductive Potential ☐ Adult Female – Reproductive Potential ☐ Female Child – NOT of Reproductive Potential ☐ Female Child – Reproductive Potential**	Quantity _____ No refills **For Follicular or Marginal Zone Lymphoma:** The recommended starting dose of Revlimid is 20mg/day orally for Days 1-21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings.
☐ Thalomid® (thalidomide)	☐ 50mg capsule ☐ 100mg capsule	☐ Take _____capsule(s) daily ☐ Take _____capsule(s) for _____days on and _____days off --- **Multiple Myeloma**: The recommended starting dose of Thalomid is 200mg/day orally with water for a 28-day treatment cycle. Dosing is continued or modified based upon clinical and laboratory findings. **Erythema Nodosum Leprosum**: The recommended starting dose of Thalomid is 100 to 300mg/day with water for an episode of cutaneous ENL. Up to 400mg/day for severe cutaneous ENL. Dosing is continued or modified based upon clinical and laboratory findings. **Authorization #** _____ **Date** _____ **(To be filled in by healthcare provider)** **Patient type from PPAF (check one): ☐ Adult Male ☐ Male Child ☐ Adult Female – NOT of Reproductive Potential ☐ Adult Female – Reproductive Potential ☐ Female Child – NOT of Reproductive Potential ☐ Female Child – Reproductive Potential**	Quantity _____ No refills
☐ Other			

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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