

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 Osteoporosis

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 _____

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 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

Medication	Strength/Formulation	Directions	Quantity/Refills
Evenity® (romosozumab-aqqg)	Two-pack carton of 105mg/1.17mL prefilled syringes Total dose 210mg	Inject 210mg (two, 105mg syringes sequentially) subcutaneously once every month for 12 doses in the abdomen, thigh or upper arm. Note: Evenity must be administered by a healthcare provider.	1 carton (2 syringes) Other _____ Refills _____
Forteo® (teriparatide [rDNA origin])	560mcg/2.24mL pre-filled pen [containing 28 daily doses of 20mcg]	Inject 20mcg subcutaneously once daily.	1-month supply 3-month supply Refills _____
Prolia® (denosumab)	60mg/1mL prefilled syringe	Administer 60mg every 6 months as a subcutaneous injection in the upper arm, upper thigh or abdomen. Note: Prolia must be administered by a healthcare provider.	1 syringe Other _____ Refills _____
Tymlos® (abaloparatide)	3120mcg/1.56mL pre-filled pen [containing 30 daily doses of 80mcg]	Inject 80mcg subcutaneously once daily.	Dispense: 1-month supply 3-month supply Refills _____
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			Send quantity sufficient for medication days supply.

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.

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.