

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](http://MyAccredoPatients.com) to log in or get started.

Prescription & Enrollment Form

# Rheumatoid Arthritis – Humira and Biosimilars

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 \_\_\_\_\_

## 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:  
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**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 weight \_\_\_\_\_ Date weight 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
Amjevita™ (adalimumab-atto) Citrate Free Patient weight is requested for pediatric patients: _____ kg	10mg/0.2mL prefilled syringe (PFS) 20mg/0.4mL PFS 40mg/0.8mL SureClick AutoInjector 40mg/0.8mL PFS	Inject 10mg subcutaneously every other week Inject 20mg subcutaneously every other week Inject 40mg subcutaneously every other week Inject 80mg subcutaneously every other week Inject 40mg subcutaneously every week Other _____	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Cyltezo® (adalimumab-adbm) Citrate Free Patient weight is requested for pediatric patients: _____ kg	10mg/0.2mL PFS 20mg/0.4mL PFS 40mg/0.8mL pen 40mg/0.8mL PFS	Inject 10mg subcutaneously every other week Inject 20mg subcutaneously every other week Inject 40mg subcutaneously every other week Inject 80mg subcutaneously every other week Inject 40mg subcutaneously every week Other _____	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
adalimumab-adbm Citrate Free Patient weight is requested for pediatric patients: _____ kg	10mg/0.2mL PFS 20mg/0.4mL PFS 40mg/0.8mL pen 40mg/0.8mL PFS	Inject 10mg subcutaneously every other week Inject 20mg subcutaneously every other week Inject 40mg subcutaneously every other week Inject 80mg subcutaneously every other week Inject 40mg subcutaneously every week Other _____	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Hadlima™ (adalimumab-bwwd) Citrate Free	40mg/0.8mL PFS 40mg/0.4mL PFS 40mg/0.8mL PushTouch Autoinjector 40mg/0.4mL PushTouch Autoinjector	Inject 40mg subcutaneously every other week Inject 80mg subcutaneously every other week Inject 40mg subcutaneously every week Other _____	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Humira® (adalimumab) Patient weight is requested for pediatric patients: _____ kg	10mg/0.1mL PFS    20mg/0.2mL PFS 40mg/0.4mL PFS (citrate free) 40mg/0.4mL Pen (citrate free) 40mg/0.8mL PFS 40mg/0.8mL Pen 80mg/0.8mL Pen (citrate free)	Inject 10mg subcutaneously every other week Inject 20mg subcutaneously every other week Inject 40mg subcutaneously every other week Inject 80mg subcutaneously every other week Inject 40mg subcutaneously every week Other _____	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Other _____			
<b>Ancillary Supplies: (Prescriber to strike through if not required)</b> 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.

**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

Medication	Strength/Formulation	Directions	Quantity/Refills
Hyrimoz® (adalimumab-adaz) Citrate Free Patient weight is requested for pediatric patients: _____ kg	10mg/0.1mL PFS 20mg/0.2mL PFS 40mg/0.4mL pen 40mg/0.4mL PFS 80mg/0.8mL pen	Inject 10mg subcutaneously every other week Inject 20mg subcutaneously every other week Inject 40mg subcutaneously every other week Inject 80mg subcutaneously every other week Inject 40mg subcutaneously every week Other _____	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
adalimumab-adaz Citrate Free	40mg/0.4mL pen 40mg/0.4mL PFS	Inject 40mg subcutaneously every other week Inject 80mg subcutaneously every other week Inject 40mg subcutaneously every week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Idacio® (adalimumab-aacf) Citrate Free Patient weight is requested for pediatric patients: _____ kg	40mg/0.8mL PFS 40mg/0.8mL Pen	<b>For Adults and Children 2 yrs and older weighing 30kg (66 lbs) and greater:</b> Inject 40mg subcutaneously every other week <b>Adults</b> Inject 40mg subcutaneously every other week Inject 80mg subcutaneously every other week Inject 40mg subcutaneously every week Other _____	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Other _____			
<b>Ancillary Supplies: (Prescriber to strike through if not required)</b> 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.

**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.