

Please fax both pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.412.4764.

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



Four simple steps to submit your referral.

## 1 Patient Information



Please attach 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 \_\_\_\_\_

Male  Female Last 4 digits of SSN \_\_\_\_\_ Date of birth \_\_\_\_\_

Street address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Parent/guardian (if applicable) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Alternate caregiver/contact \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail 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 \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_

Prescriber's title \_\_\_\_\_ If NP or PA, under direction of Dr. \_\_\_\_\_

Office address \_\_\_\_\_

Office contact and title \_\_\_\_\_

Office contact phone number \_\_\_\_\_ Office contact e-mail \_\_\_\_\_

Office/Infusion clinic name \_\_\_\_\_ Office/Infusion clinic affiliation \_\_\_\_\_

Street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ NPI # \_\_\_\_\_ License # \_\_\_\_\_

Deliver product to:  Office  Patient's home  Clinic Clinic location \_\_\_\_\_

## 3 Clinical Information

Primary ICD-10 code: \_\_\_\_\_

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
			Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
			Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
			Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
			Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
			Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy		As needed for administration	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 (sign below) (Physician attests this is his/her legal signature. NO STAMPS) PHYSICIAN SIGNATURE REQUIRED**

**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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