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

Rheumatoid Arthritis – Injectable

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:

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
☐ Cimzia® (certolizumab pegol)	☐ 200mg/mL solution in a single-dose prefilled syringe (PFS) ☐ 200mg/mL lyophilized powder in a single-dose vial for reconstitution	**Loading dose:** ☐ Inject 400mg subcutaneously at weeks 0, 2 and 4	1 starter kit No refills
		Maintenance dose: ☐ Inject 400mg subcutaneously every 4 weeks ☐ Inject 200mg subcutaneously every 2 weeks ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Cosentyx® (secukinumab)	☐ 75mg PFS ☐ 150mg PFS ☐ 150mg Pen ☐ 300mg (2x150mg) PFS ☐ 300mg (2x150mg) Pen ☐ 300mg Unoready Pen	**Loading dose:** ☐ Inject _____mg subcutaneously at weeks 0, 1, 2, 3 and 4 followed by _____ every 4 weeks	QS for 5 doses No refills
		Maintenance dose: ☐ Inject _____mg subcutaneously every 4 weeks ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Enbrel® (etanercept)	☐ 25mg Single Use vial ☐ 25mg PFS ☐ 50mg PFS ☐ 50mg SureClick™ ☐ 50mg Mini Cartridge	☐ Inject 50mg subcutaneously once a week ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Kevzara® (sarilumab)	☐ 150mg/1.14mL prefilled pen ☐ 150mg/1.14mL PFS ☐ 200mg/1.14mL prefilled pen ☐ 200mg/1.14mL PFS	☐ Inject 150mg subcutaneously every 2 weeks ☐ Inject 200mg subcutaneously every 2 weeks	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other _____			
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.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

SIGN HERE

If NP or PA, under direction of Dr. _____ **State License No:** _____

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
☐ Ilaris® (canakinumab) Patient's weight (kg): _____	**Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)** ☐ 4 years and older and weight 15kg to 40kg (2mg/kg): _____mg ☐ 4 years and older and weight more than 40kg: 150mg	☐ Subcutaneously every 8 weeks	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
	Still's Disease (4mg/kg) ☐ _____mg	☐ Subcutaneously every 4 weeks	
	Systemic Juvenile Idiopathic Arthritis (SJIA) ☐ 2 years and older and weight greater than or equal to 7.5kg (4mg/kg/dose): _____mg	☐ Subcutaneously every 4 weeks	
	Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency (HIDS/MKD), and Familial Mediterranean Fever (FMF) ☐ 2 years and older and weight less than or equal to 40kg (2mg/kg up to 4mg/kg): _____mg ☐ 2 years and older and weight more than 40kg: 150mg	☐ Subcutaneously every 4 weeks	
☐ Other _____			
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.

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**

If NP or PA, under direction of Dr. _____ **State License No:** _____

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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