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

Sickle Cell Disease (SCD)

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 _____

Sex at birth: ☐ Male ☐ Female Preferred pronouns _____ 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 _____

Insurance company _____ Phone _____

Insured's name _____ Insured's employer _____

Relationship to patient _____ Identification # _____ Policy/group # _____

Prescription card: ☐ Yes ☐ No If yes, carrier _____ Policy # _____ Group # _____

Patient eligible for Medicare? ☐ Yes ☐ No Does patient have a secondary insurance? ☐ Yes ☐ No

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 e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

3 Clinical Information

Sickle Cell Diagnosis **(REQUIRED)**: ☐ D57 (sickle cell disorders) ☐ D57.0 (Hb-SS disease with crisis) ☐ D57.1 (SCD without crisis)
☐ D57.2 (Sickle-cell/Hb-C disease) ☐ D57.00 (Hb-SS disease with crisis, unspecified)
☐ D57.40 (Sickle-cell thalassemia without crisis) ☐ D57.20 (Sickle-cell/Hb-C disease without crisis)
☐ D57.219 (Sickle-cell/Hb-C disease with crisis, unspecified) ☐ Other _____

Date recorded _____ Height _____ cm/in Weight _____ kg/lbs Date taken _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Additional clinical information _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

<table>
<tr><th>Medication</th><th>Dose</th><th>Directions</th><th>Quantity/Refills</th></tr>
<tr><td>☐ Endari®</td><td>5 Gram (GM) Packet</td><td>
<table>
<tr><th>Weight in kilograms</th><th>Per dose in grams</th><th>Per day in grams</th><th>Packets per dose</th><th>Packets per day</th></tr>
<tr><td>less than 30</td><td>5</td><td>10</td><td>1</td><td>2</td></tr>
<tr><td>30 to 65</td><td>10</td><td>20</td><td>2</td><td>4</td></tr>
<tr><td>greater than 65</td><td>15</td><td>30</td><td>3</td><td>6</td></tr>
</table>
☐ Mix 1 packet (5 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4-6 ounces of food and take by mouth 2 times daily.
☐ Mix 2 packet(s) (10 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4-6 ounces of food and take by mouth 2 times daily.
☐ Mix 3 packet(s) (15 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4-6 ounces of food and take by mouth 2 times daily.

☐ Other _____
</td><td>☐ 1-month supply
☐ 3-month supply
☐ Other
_____
Number refills authorized _____</td></tr>
<tr><td rowspan="3">☐ Oxbryta®</td><td>☐ 500mg Tablets for oral use</td><td>☐ Take 3 tablets (1500mg) by mouth once daily

☐ Other _____</td><td rowspan="3">☐ 1-month supply
☐ 3-month supply
☐ Other
_____
Number refills authorized _____</td></tr>
<tr><td>☐ 300mg Tablets for oral use</td><td>
<table>
<tr><th>Weight in kilograms</th><th>Recommended dose (once daily)</th></tr>
<tr><td>40kg or greater</td><td>1,500mg</td></tr>
<tr><td>20kg to less than 40kg</td><td>900mg</td></tr>
<tr><td>10kg to less than 20kg</td><td>600mg</td></tr>
</table>
☐ Take 5 tablets (1500mg) by mouth once daily.
☐ Take 3 tablets (900mg) by mouth once daily.
☐ Take 2 tablets (600mg) by mouth once daily.

☐ Other _____
</td></tr>
<tr><td>☐ 300mg Tablets for oral suspension</td><td>
<table>
<tr><th>Weight in kilograms</th><th>Recommended dose (once daily)</th></tr>
<tr><td>40kg or greater</td><td>1,500mg</td></tr>
<tr><td>20kg to less than 40kg</td><td>900mg</td></tr>
<tr><td>10kg to less than 20kg</td><td>600mg</td></tr>
</table>
☐ Take 5 tablets (1500mg) dispersed for oral suspension in 25mL of clear drink daily.
☐ Take 3 tablets (900mg) dispersed for oral suspension in 15mL of clear drink daily.
☐ Take 2 tablets (600mg) dispersed for oral suspension in 10mL of clear drink daily.

☐ Other _____
</td></tr>
<tr><td colspan="4">Place tablets for oral suspension immediately before administration in a cup and in room temperature clear liquid (such as drinking water or clear soda) before swallowing. Minimum recommended volume of clear drink is 5mL (1 teaspoon) per tablet for oral suspension.</td></tr>
</table>

Prescriber's signature required (sign below) (Prescriber 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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