

Four simple steps to submit your referral.

Do not contact patient, benefits check only

1 Patient Information

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 _____

Parent/guardian (if applicable) _____ Phone _____

Patient's primary language: English Other If other, please specify _____



Please attach copies of front and back of patient's insurance cards.

Insurance Company _____ Phone _____

Identification # _____ Policy/group # _____

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

2 Prescriber Information

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

CHECK ONE

ICD-10 immunology: D80.0 Congenital Hypogam D83.9 CVID (unspecified) D81.9 SCID (unspecified)

ICD-10 neurology: G61.81 CIDP G61.82 MMN G35 MS (rel remit) G61.0 GBS G70.01 MG

ICD-10 rheumatology: M33.20 Polymyositis M33.90 Dermatomyositis

Other _____

Other drugs used to treat the disease _____

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

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

Adverse reaction medications: *(Accredo will provide an epinephrine auto injector with the first fill only)*

- Epinephrine 0.3mg auto-injector 2-pk for patients weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose
- Epinephrine 0.15mg auto-injector 2-pk for patients weighing less than 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose
- Diphenhydramine 25mg by mouth for mild allergic reactions and 50mg for moderate to severe

Supplies: *(please strike through if not required)*

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

Quantity/Refills: Dispense 1-month supply. Refill x 1 year unless noted otherwise. Dispense 90-day supply. Refill x 1 year unless noted otherwise.

Other _____

Accredo nursing services: *(please strike through if not required)*

Skilled nursing visits to educate patient on subcutaneous access, medication administration, use of supplies, therapy and disease state and to assess general status and response to therapy; patient discharged from nursing once teaching complete.

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

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**

Pharmacist selection 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.

Prior authorization checklist

Primary immune deficiency disease (PIDD)

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients with PIDD. Coverage criteria may vary by payer.

Referral form ¹ (not required for electronic prescriptions)	
	Completed Immunoglobulin (Ig) referral form (available at accredo.com)
	Copies of the front and back of all medical insurance and prescription benefits cards
Clinical documents	
	History and Physical (H&P) and progress notes (within past 6 months) Note: H&P to include documented infection history/treatment
	Pre-treatment IgG, IgA, IgM, and Ig subclass serum levels (drawn on two different occasions when available) Current IgG, IgA, IgM, and Ig subclass serum levels
	Pre- and post-antigen testing (tetanus, pneumococcal polysaccharide or H Influenza type B) AND documentation of vaccine administration date

Medicare-approved PIDD diagnosis		
D80 – Immunodeficiency with predominantly antibody defects	D81.0 – Severe combined immunodeficiency (SCID) with reticular dysgenesis	D82.0 – Wiskott-Aldrich syndrome
D80.0 – Hereditary hypogammaglobulinemia	D81.1 – Severe combined immunodeficiency (SCID) with low T- and B-cell numbers	D82.1 – Di George’s syndrome
D80.2 – Selective deficiency of immunoglobulin A (IgA)	D81.2 – Severe combined immunodeficiency (SCID) with low or normal B-cell numbers	D82.4 – Hyperimmunoglobulin E (IgE) syndrome
D80.3 – Selective deficiency of immunoglobulin G (IgG) subclasses	D81.5 – Purine nucleoside phosphorylase (PNP) deficiency	D83 – Common variable immunodeficiency (CVID)
D80.4 – Selective deficiency of immunoglobulin M (IgM)	D81.6 – Major histocompatibility complex class I deficiency	D83.0 – CVID with predominant abnormalities of B-cell numbers and function
D80.5 – Immunodeficiency with increased immunoglobulin M (IgM)	D81.7 – Major histocompatibility complex class II deficiency	D83.1 – CVID with predominant immunoregulatory T-cell disorders
D80.6 – Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia	D81.89 – Other combined immunodeficiencies	D83.2 – CVID with autoantibodies to B- or T-cells
D80.7 – Transient hypogammaglobulinemia of infancy	D81.9 – Combined immunodeficiency, unspecified	D83.8 – Other CVIDs
D81 – Combined immunodeficiencies	D82 – Immunodeficiency associated with other major defects	D83.9 – CVID, unspecified
		G11.3 – Cerebellar ataxia with defective DNA repair

To receive in-home administration for intravenous immune globulin (IVIG) for the treatment of PIDD, Medicare Part B patients must be enrolled in the IVIG Demonstration initiative. For further information visit: <https://med.nordianmedicare.com/web/ivig>

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.

1. For referral forms visit [accredo.com](https://www.accredo.com).

Prior Authorization Checklist Neuromuscular Disorders¹

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients. Coverage criteria many vary by payer.

Referral Form (not required for electronic prescriptions)	
	Completed Immunoglobulin (Ig) referral form (available at accredo.com)
	Copies of the front and back of all medical insurance and prescription benefits cards
Clinical Documents	
	History and Physical (H&P) and progress notes ² (within past 6 months) Note: Diagnosis of the disorder must be unequivocal
	Documentation that other causes of demyelinating neuropathy have been excluded
Testing documentation:	
<input type="checkbox"/>	Electrophysiological motor-sensory nerve conductions
<input type="checkbox"/>	Electromyography (EMG)
<input type="checkbox"/>	Cerebrospinal fluid (CSF)
<input type="checkbox"/>	Biopsy (muscle-nerve) - if necessary

Additional Requirements for Myasthenia Gravis	
	Tensilon test results
	Refractory to corticosteroids over a 6 month period documentation
	Ongoing Ig treatment must be documented in H&P and progress notes ²
Additional Requirements for Polymyositis and Dermatomyositis Diagnosis	
	Creatine phosphokinase (CPK) values
	Electromyography (EMG) and/or muscle biopsy results

¹ This Neuromuscular Disorders checklist is based on Medicare Part B guidelines related to Guillain-Barre' syndrome (GBS), relapsing-remitting multiple sclerosis, chronic inflammatory demyelinating polyneuropathy (CIDP) (and variant syndromes such as Multifocal Motor Neuropathy (MMN)), myasthenia gravis, refractory polymyositis, and refractory dermatomyositis

² Ongoing management and documentation requirements:

- Initial improvement and continued need must be meticulously documented in progress notes
- All weaning must be attempted and documented as either amount or frequency
- Must be a stoppage in IVIG if sustained improvement is noted with weaning or no improvement has taken place at all

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.