Please fax all 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

Tremfya®

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 ______

Provider will read the following statement: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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 wt ______ Date wt 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
Tremfya®	**Psoriasis and Psoriatic Arthritis**		
	100mg/mL in each single-dose One-Press injector 100mg/mL in each single-dose prefilled syringe (PFS) 100mg/mL in each single-dose pen	Loading Dose: Inject 100mg subcutaneously at weeks 0, 4 and every 8 weeks thereafter	QS for loading period No Refills
		Maintenance Dose: Inject 100mg subcutaneously every 8 weeks	1-month supply 3-month supply Other ______ Refills ______
	Ulcerative Colitis		
	Loading: 200mg/20mL single-dose vial	Loading Dose: Infuse 200mg IV at weeks 0, 4 and 8	QS for loading period No Refills
	Maintenance: 100mg/mL in each single-dose One-Press injector 100mg/mL in each single-dose PFS 100mg/mL in each single-dose pen 200mg/2mL in each single-dose PFS 200mg/2mL in each single-dose pen	Maintenance Dose: Inject 100mg subcutaneously at week 16 and every 8 weeks thereafter Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter	1-month supply 3-month supply Other ______ Refills ______
	Crohn's		
	Loading: 200mg/20mL single-dose vial 200mg/2mL in each single-dose PFS 200mg/2mL in each single-dose pen	Loading Dose: Infuse 200mg IV at weeks 0, 4 and 8 Inject 400mg (2-200mg/2mL) subcutaneously at weeks 0, 4 and 8	QS for loading period No Refills
	Maintenance: 100mg/mL in each single-dose One-Press injector 100mg/mL in each single-dose PFS 100mg/mL in each single-dose pen 200mg/2mL in each single-dose PFS 200mg/2mL in each single-dose pen	Maintenance Dose: Inject 100mg subcutaneously at week 16 and every 8 weeks thereafter Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter	1-month supply 3-month supply Other ______ Refills ______
Other			

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

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