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 <u>MyAccredoPatients.com</u> to log in or get started.

Prescription & Enrollment Form Ulcerative Colitis – Humira and Biosimilars

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 Curre	ent patient			
Patient's first name		Last name		Middle initial
Preferred patient first nar	ne	Preferre	d patient last name	
Sex at birth: Male I	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 applic	able)			
	Cell phone			
Alternate caregiver/contac	:t			
Home phone	Cell phone		Email address	
OK to leave message w	ith alternate caregiver/contact			
Patient's primary languag	e: English Other If other, p	please specify		

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date		Time		Date medication ne	eded	
Office/clinic/institu	ution name					
Prescriber info: Pr	rescriber's first nan	ne		Last	name	
Prescriber's title _			If NP	or PA, under direc	tion of Dr.	
Office phone		Fax		NPI #	License #	
Office contact and	d title			Office	contact email	
Office street addre	ess				Suite #	
City			State		Zip	
					mplete information below dotted	
Infusion info: Infu	sion site name			Clinic/hospital	affiliation	
Site street address	S				Suite #	
City			State		Zip	
Infusion site contact	ct	Phor	ne	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 r	neds	

Patient's first name	Last name	Middle initial Date of birth	
Prescriber's first name	Last name	Phone	
Prescriber's first name	Last name	Phone	

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
adalimumab- aacf Citrate Free (ADULT)	40mg/0.8mL pen	Loading dose: Inject 160mg on day 1OR Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Other Refills
Amjevita™ (adalimumab- atto) Citrate Free (ADULT)	40mg/0.8mL SureClick Autoinjector 40mg/0.8mL prefilled syringe (PFS) 40mg/0.4mL SureClick Autoinjector 40mg/0.4mL PFS 80mg/0.8mL SureClick Autoinjector	Loading dose: Inject 160mg on day 1OR Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
	Song/o.one Surechek Autonjector	Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other
Cyltezo® (adalimumab- adbm) Citrate Free (ADULT)	40mg/0.8mL pen 40mg/0.8mL PFS	Loading dose: Inject 160mg on day 1OR Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
,		Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other
adalimumab- adbm Citrate Free (ADULT)	40mg/0.8mL pen 40mg/0.8mL PFS	Loading dose: Inject 160mg on day 1OR Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other
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)



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.

Patient's first name La	ist name	Middle initial	Date of birth
Prescriber's first name	Last name	Phone	

Prescribing Information 4

Medication	Strength/Formulation	Directions	Quantity/Refills
Hadlima™ (adalimumab- bwwd) Citrate Free (ADULT)	40mg/0.8mL PFS 40mg/0.4mL PFS 40mg/0.8mL PushTouch Autoinjector 40mg/0.4mL PushTouch	Loading dose: Inject 160mg on day 1OR Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
	Autoinjector	Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other
Humira® (adalimumab) (ADULT)	80mg/0.8mL prefilled pen Starter Package (3 pens) 40mg/0.8mL pens starter kit 40mg/0.4mL PFS for starter dose	Loading dose: 160mg injected day 1OR 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1 starter kit -OR- QS for 1-month loading dose No Refills
	40mg/0.4mL citrate-free pen 40mg/0.4mL citrate-free PFS 40mg/0.8mL pen 40mg/0.8mL PFS	Maintenance dose: Inject 40mg subcutaneously every other week.	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other
Humira® (adalimumab) (PEDIATRIC)	80mg/0.8mL prefilled pen UC Starter Package (4 pens) 40mg/0.4mL PFS for starter dose	Loading dose: 160mg injected day 1OR 80mg injected each day 1 and day 2 then 80mg administered weekly for 2 weeks (a dose on day 8 and day 15) then maintenance dose starting on day 29.	1 starter kit -OR- QS for 1-month loading dose No Refills
	40mg/0.4mL PFS for starter dose	80mg subcutaneously on day 1, then 40mg administered weekly for 2 weeks (a dose on day 8 and day 15) then maintenance dose starting on day 29.	
	40mg/0.4mL citrate-free pen 40mg/0.4mL citrate-free PFS 40mg/0.8mL pen 40mg/0.8mL PFS 80mg/0.8mL citrate-free pen 20mg/0.2mL PFS	Maintenance dose: Inject 80mg subcutaneously every other week Inject 40mg subcutaneously every week Inject 40mg subcutaneously every other week Inject 20mg subcutaneously every week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other
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)



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.

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
Hyrimoz® (adalimumab- adaz) Citrate Free (ADULT)	80mg/0.8mL Pen Starter Pack (3 pens)	Loading dose: Inject 160mg on day 1OR Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
	40mg/0.4mL pen 40mg/0.4mL PFS	Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other
adalimumab- adaz Citrate Free (ADULT)	40mg/0.4mL pen 40mg/0.4mL PFS	Loading dose: Inject 160mg on day 1OR Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other
Idacio [®] (adalimumab- aacf) Citrate Free (ADULT)	40mg/0.8mL PFS 40mg/0.8mL Pen	Loading dose: Inject 160mg on day 1OR Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other
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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