

Please fax all pages of completed form to your team at 808.650.6487.

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Prescription & Enrollment Form

# Ulcerative Colitis – Humira and Biosimilars

**accredo**<sup>®</sup>

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:

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**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
adalimumab-aacf Citrate Free (ADULT)	40mg/0.8mL pen	<b>Loading dose:</b> Inject 160mg on day 1 --OR-- 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
		<b>Maintenance dose:</b> 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	<b>Loading dose:</b> Inject 160mg on day 1 --OR-- 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
		<b>Maintenance dose:</b> 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	<b>Loading dose:</b> Inject 160mg on day 1 --OR-- 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
		<b>Maintenance dose:</b> 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	<b>Loading dose:</b> Inject 160mg on day 1 --OR-- 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
		<b>Maintenance dose:</b> 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.

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
Hadlima™ (adalimumab- bwwd) Citrate Free (ADULT)	40mg/0.8mL PFS	<b>Loading dose:</b> Inject 160mg on day 1 --OR-- 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 PFS 40mg/0.8mL PushTouch Autoinjector 40mg/0.4mL PushTouch Autoinjector	<b>Maintenance dose:</b> 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	<b>Loading dose:</b> 160mg injected day 1 --OR-- 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	<b>Maintenance dose:</b> 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	<b>Loading dose:</b> 160mg injected day 1 --OR-- 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	<b>Maintenance dose:</b> 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			

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Date

Dispense as written

Date

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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)	<b>Loading dose:</b> Inject 160mg on day 1 --OR-- 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	<b>Maintenance dose:</b> 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	<b>Loading dose:</b> Inject 160mg on day 1 --OR-- 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
		<b>Maintenance dose:</b> 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	<b>Loading dose:</b> Inject 160mg on day 1 --OR-- 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
		<b>Maintenance dose:</b> Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Other			

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