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
Ulcerative Colitis

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 _____

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
☐ Simponi® (golimumab)	☐ 100mg/mL in each single-dose prefilled syringe (PFS) ☐ 100mg/mL in each single-dose pen	**Loading dose:** ☐ Inject 200mg subcutaneously at week 0, followed by 100mg subcutaneously at week 2	QS for 42-day supply loading dose No Refills
		Maintenance dose: ☐ Inject 100mg subcutaneously every 4 weeks.	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Stelara® (ustekinumab)	☐ 90mg/mL in each single-dose PFS	**Maintenance dose:** ☐ Inject 90mg subcutaneously every 8 weeks.	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
		Maintenance Dose Only Needed. If loading dose is needed, please see IV referral form. By selecting Stelara on this form, I am indicating that patient has already received/does not need IV loading dose at this time.	
☐ Xeljanz®	☐ 10mg tablets	**Loading dose:** ☐ Take 10mg by mouth twice daily for 8 weeks, followed by 5mg twice daily	QS for 2-month loading dose No Refills
	☐ 5mg tablets ☐ 10mg tablets	**Maintenance dose:** ☐ Take 10mg by mouth twice daily ☐ Take 5mg by mouth twice daily ☐ Take 5mg by mouth once daily	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Xeljanz XR™	☐ 22mg ER tablets	**Loading dose:** 22mg once daily for at least 8 weeks, followed by 11mg once daily	QS for 2-month loading dose No Refills
	☐ 11mg ER tablets	**Maintenance dose:** Take 11mg by mouth once daily	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Zeposia® (ozanimod)	**Starter dose:** ☐ Starter Pack (28 day) ☐ Starter Pack (7 day)	Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule for 3 days, then one 0.92mg capsule daily thereafter	1 kit No Refills
	Maintenance dose: ☐ 0.92mg capsules	Take one capsule daily	☐ 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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