

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](http://MyAccredoPatients.com) to log in or get started.

## Prescription & Enrollment Form Verzenio™ (abemaciclib)

*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'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 \_\_\_\_\_

Deliver product to:    Prescriber's office    Patient's home

### 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
Verzenio™ (abemaciclib)	50mg tablets 100mg tablets 150mg tablets 200mg tablets	Take _____ mg twice daily Other _____	Dispense: 28-day supply Other _____ Refills _____

**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.