

# Prescription & Enrollment Form Anemia



677 Ala Moana Blvd., Suite 404,  
Honolulu, HI 96813-5412

**Four simple steps  
to submit your referral.**

## 1 PATIENT INFORMATION

New patient  Current

Patient's first name \_\_\_\_\_  
 Last name \_\_\_\_\_ Middle initial \_\_\_\_\_  
 Date of birth \_\_\_\_\_  Male  Female Last 4 digits of SSN \_\_\_\_\_  
 Street address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Parent/guardian (if applicable) \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
 Cell phone \_\_\_\_\_ Evening phone \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Patient's primary language:  English  Other If other, please specify \_\_\_\_\_

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company \_\_\_\_\_ Phone \_\_\_\_\_  
 Insured's name \_\_\_\_\_  
 Insured's employer \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Identification # \_\_\_\_\_ Policy/group # \_\_\_\_\_  
 Prescription card:  Yes  No If yes, carrier \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Is patient eligible for Medicare?  Yes  No  
 Does patient have a secondary insurance?  Yes  No

## 2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_  
 Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_  
 Prescriber's title \_\_\_\_\_  
 If NP or PA, under direction of Dr. \_\_\_\_\_  
 Office contact and title \_\_\_\_\_  
 Office contact e-mail \_\_\_\_\_  
 Office/clinic/institution name \_\_\_\_\_  
 Clinic/hospital affiliation \_\_\_\_\_  
 Street address \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 NPI # \_\_\_\_\_ License # \_\_\_\_\_  
 Deliver product to:  Office  Patient's home  Clinic  
 Clinic location \_\_\_\_\_

## 3 CLINICAL INFORMATION

Primary ICD-10 code: \_\_\_\_\_  
 Current weight \_\_\_\_\_ kg/lbs Date recorded \_\_\_\_\_  
 Laboratory results: Hematocrit \_\_\_\_\_ % Date \_\_\_\_\_  
 Hemoglobin \_\_\_\_\_ g/dl Date \_\_\_\_\_  
 Platelets \_\_\_\_\_ Date \_\_\_\_\_  
 EXPECTED DATE OF FIRST/NEXT INJECTION \_\_\_\_\_  
 DATE OF LAST INJECTION (if applicable) \_\_\_\_\_  
 Agency nurse to visit home for injection:  Yes  No  
 Agency name & phone \_\_\_\_\_  
 NKDA  Known drug allergies \_\_\_\_\_  
 Concurrent meds \_\_\_\_\_

## 4 PRESCRIBING INFORMATION

Medication	Directions	Quantity/Refills
<input type="checkbox"/> Aranesp® (darbepoetin alfa)	Inject dose _____ mcg/kg or _____ mcg Route: <input type="checkbox"/> IV <input type="checkbox"/> SC Dosing directions (include daily, weekly, cyclic, one-time, duration of txt., etc.) _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Epogen® (epoetin alfa)	Inject dose _____ units/kg or _____ units Route: <input type="checkbox"/> IV <input type="checkbox"/> SC	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Procrit® (epoetin alfa)	Dosing directions (include daily, weekly, cyclic, one-time, duration of txt., etc.) _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Retacrit™ (epoetin-alfa-ebpx)		
<input type="checkbox"/> Other		Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<b>Supplies (if needed per dose):</b> <input type="checkbox"/> 1mL syringe <input type="checkbox"/> 3mL syringe <input type="checkbox"/> 7G 5/8" needle <input type="checkbox"/> 25G 5/8" needle <input type="checkbox"/> 271/2G 5/8" needle – pediatrics only		Send quantity sufficient for medication days supply
<input type="checkbox"/> Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy as needed for administration.		Send quantity sufficient for medication days supply

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

**PHYSICIAN SIGNATURE REQUIRED**

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.

**Please fax completed form to your drug therapy 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.**

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