Prescription & Enrollment Form
Anemia

Four simple steps to submit your referral.

accredo®

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

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 _____
Hemaglobin _____ 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
❑ Aranesp® (darbepoetin alfa)	Inject dose _____ mcg/kg or _____ mcg Route: ❑ IV ❑ SC Dosing directions (include daily, weekly, cyclic, one-time, duration of txt., etc.) _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Epogen® (epoetin alfa) ❑ Procrit® (epoetin alfa) ❑ Retacrit™ (epoetin-alfa-ebpx)	Inject dose _____ units/kg or _____ units Route: ❑ IV ❑ SC Dosing directions (include daily, weekly, cyclic, one-time, duration of txt., etc.) _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Other _____ _____ _____		Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
Supplies (if needed per dose): ❑ 1mL syringe ❑ 3mL syringe ❑ 7G 5/8" needle ❑ 25G 5/8" needle ❑ 27 1/2G 5/8" needle – pediatrics only		Send quantity sufficient for medication days supply
❑ 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.

PHYSICIAN SIGNATURE REQUIRED

Prescriber's signature (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.

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 to log in or get started.

ANM-00001-H-111820 amc10159 CRP1905_A0228