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

Arthritis and Inflammatory — Subcutaneous

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 _____

Sex at birth: ☐ Male ☐ Female 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
☐ Actemra® (tocilizumab)	☐ Actemra Actpen 162mg/0.9mL ☐ Actemra 162mg/0.9mL Prefilled Syringe	**Rheumatoid Arthritis (RA):** ☐ 162mg subcutaneously once every week (greater than or equal to 100kg) ☐ 162mg subcutaneously every other week (less than 100kg) **Polyarticular Juvenile Idiopathic Arthritis (PJIA):** ☐ 162mg/dose subcutaneously once every 3 weeks (2 years or older, Less than 30kg) ☐ 162mg/dose subcutaneously once every 2 weeks (2 years or older, 30kg or greater) **Systemic Juvenile Idiopathic Arthritis (SJIA):** ☐ 162mg/dose subcutaneously once every 2 weeks. (2 years or older, Less than 30kg) ☐ 162mg/dose subcutaneously once every week. (2 years or older, 30kg or greater) **Giant cell arteritis:** ☐ 162mg subcutaneously once every week	☐ 1-month supply. Refill x 1 year unless noted otherwise. ☐ 90-day supply. Refill x 1 year unless noted otherwise. ☐ Other Refills
☐ Orencia® (abatacept)	☐ 125mg/mL PFS ☐ 125mg/mL Clickject Autoinjector	**Rheumatoid Arthritis (RA):** Inject 125mg subcutaneously once weekly	☐ 1-month supply. Refill x 1 year unless noted otherwise. ☐ 90-day supply. Refill x 1 year unless noted otherwise. ☐ Other Refills
	☐ 50mg/0.4mL PFS ☐ 87.5mg/0.7mL PFS ☐ 125mg/mL PFS ☐ 125mg/mL Clickject Autoinjector	**Juvenile Idiopathic Arthritis (JIA):** ☐ 50mg subcutaneously once weekly (2 years and older and weighing 10kg to less than 25kg) ☐ 87.5mg subcutaneously once weekly (weight 25kg or less than 50kg) ☐ 125mg PFS subcutaneously once weekly (weight greater than or equal to 50kg) ☐ 125mg Clickject Autoinjector subcutaneously once weekly (weight greater than or equal to 50kg)	
☐ Simponi® (golimumab)	☐ Simponi 50mg/0.5mL Autoinject Pen ☐ Simponi 50mg/0.5mL Syringe	☐ 50mg subcutaneously once per month	☐ 1-month supply. Refill x 1 year unless noted otherwise. ☐ 90-day supply. Refill x 1 year unless noted otherwise. ☐ Other Refills
☐ Other			☐ 1-month supply. Refill x 1 year unless noted otherwise. ☐ 90-day supply. Refill x 1 year unless noted otherwise. ☐ Other Refills

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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