Prescription & Enrollment Form

Bleeding disorders

accredo®

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 by ______

Prescriber's first name ______ Last name ______

Middle initial ______ Prescriber's title ______

If NP or PA, under direction of Dr. ______

Office contact and title ______

Office contact e-mail ______ Clinic/hospital affiliation ______

Office/clinic/institution name ______

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: ______

Bleeding disorder type: ❑ A ❑ B ❑ vWD ❑ Other ______

Severity: ❑ Mild ❑ Moderate ❑ Severe ❑ Type vWD ______

Height ______ Weight ______ IV access: ❑ PIV/butterfly ❑ PICC

❑ Implanted port ❑ Central line

Inhibitor: ❑ No ❑ Yes (______ B.U.)

Target joint(s): ❑ No ❑ Yes Location ______

Additional clinical information ______

❑ NKDA ❑ Known drug allergies ______

Concurrent meds ______

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Refills
	Dosage: Mild units/kg ______ Severe units/kg ______	**Prophylaxis:** Dispense ______ doses/week for a duration of ______ months **Episodic:** Dispense ______ doses for mild/ ______ doses for severe	
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Ancillary medication/supplies/nursing:

❑ Amicar® ______ mg Directions ______ ❑ Heparin ______ units/mL ______ mL flush

❑ Stimate® 1.5mg/mL spray in ❑ each ❑ both nostril(s), as directed ❑ Saline ______ mL ______ mL flush

❑ Emla® Apply topically as needed to IV site 30–60 minutes prior to insertion prn. ______

❑ LMX™ Apply topically as needed to IV site 30–60 minutes prior to insertion prn. ______

❑ Cryo-Cuff® to be applied to affected site/joint prn. ______ Site ______

❑ Skilled nursing visits to be provided for infusions ❑ Skilled nursing visits to be provided for teaching

❑ Other ______

Prescription to include all necessary ancillary supplies (needles, syringes, etc.)

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 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.

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