Prescription & Enrollment Form

Oncology (oral) (A-S)

accredo®

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 # _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____

Current weight _____ kg/lbs Height _____ inches/cm

BSA _____ m² Date obtained _____

❑ NKDA ❑ Known drug allergies _____

Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ abiraterone acetate	❑ 250mg tablet ❑ 500mg tablet	❑ Take 1000mg (four 250mg tablets or two 500mg tablets) orally once daily ❑ Other _____ If patient is NOT currently receiving prednisone, prescribe below in "Other."	Quantity _____ Days supply _____ Refills _____
❑ Afinitor® (everolimus)	❑ 2.5mg tablet ❑ 5mg tablet ❑ 7.5mg tablet ❑ 10mg tablet	❑ Take one tablet daily ❑ Other _____	Quantity _____ Days supply _____ Refills _____
❑ Afinitor® **DISPERZ** (everolimus)	❑ 2mg tablet ❑ 3mg tablet ❑ 5mg tablet	❑ Dissolve _____ tablet(s) in water and drink daily ❑ Other _____	Quantity _____ Days supply _____ Refills _____
❑ Erivedge® (vismodegib)	❑ 150mg capsule	❑ Take one capsule daily ❑ Other _____	Quantity _____ Days supply _____ Refills _____
❑ erlotinib	❑ 25mg tablet ❑ 100mg tablet ❑ 150mg tablet	❑ Take one tablet daily ❑ Other _____	Quantity _____ Days supply _____ Refills _____
❑ imatinib mesylate	❑ 100mg tablet ❑ 400mg tablet	❑ Take _____ tablet(s) _____ time(s) a day ❑ Other _____	Quantity _____ Days supply _____ Refills _____
❑ Jakafi® (ruxolitinib)	❑ 5mg tablet ❑ 10mg tablet ❑ 15mg tablet ❑ 20mg tablet ❑ 25mg tablet	❑ Take _____ tablet(s) twice daily ❑ Other _____	Quantity _____ Days supply _____ Refills _____
❑ Lorbrena® (lorlatinib)	❑ 25mg tablet ❑ 100mg tablet	❑ Take ____ mg once daily ❑ Other _____	Quantity _____ Days supply _____ Refills _____
❑ Promacta® (eltrombopag)	❑ 12.5mg tablet ❑ 25mg tablet ❑ 50mg tablet ❑ 75mg tablet	❑ Take _____ tablet(s) twice daily ❑ Other _____	Quantity _____ Days supply _____ Refills _____
❑ Sprycel® (dasatinib)	❑ 20mg tablet ❑ 50mg tablet ❑ 70mg tablet ❑ 80mg tablet ❑ 100mg tablet ❑ 140mg tablet	❑ Take one tablet daily ❑ Other _____	Quantity _____ Days supply _____ Refills _____
❑ Sutent® (sunitinib malate)	❑ 12.5mg capsule ❑ 25mg capsule ❑ 37.5mg capsule ❑ 50mg capsule	❑ Take one capsule daily continuously ❑ Take _____ capsule(s) daily 4 weeks on and 2 weeks off ❑ Other _____	Quantity _____ Days supply _____ Refills _____
❑ Other _____			Quantity _____ Days supply _____ Refills _____

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 the Oncology team at 888.302.1028. To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.