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

Cibinqo™ (abrocitinib)

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 Preferred 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'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 _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

3 Clinical Information

ICD-10 code (REQUIRED): _____

☐ NKDA ☐ Known drug allergies _____

Prior anaphylactic reaction: ☐ Yes (Reason/date _____) ☐ No

Concurrent meds _____ Estimated % BSA involvement _____

Concomitant therapies: ☐ Short-acting beta agonist ☐ Long-acting beta agonist ☐ Antihistamines ☐ Decongestants ☐ Immunotherapy

☐ Inhaled corticosteroid ☐ Leukotriene modifiers ☐ Oral steroids ☐ Nasal steroids ☐ Other _____

Lab results: ☐ History of positive skin OR RAST test to a perennial aeroallergen

Pre-treatment steroid dose _____ mg Pre-treatment serum IgE level _____ IU per mL Test date _____

Pre-treatment serum eosinophils _____ cells/mcL and/or sputum eosinophils _____ Date _____

Patient wt _____ kg Date wt obtained _____

MD Specialty (required): ☐ Allergist ☐ Pulmonologist ☐ ENT ☐ Primary care ☐ Pediatrician ☐ Dermatologist ☐ Other _____

Prescription type: ☐ Naïve/new start ☐ Restart ☐ Continued therapy

Prior therapies: Please fax detailed medication history with dates of use as available. Required by some plan authrization criteria.

☐ Topical steroid(s) ☐ Oral antihistamines ☐ Topical PDE-4 inhibitor ☐ Oral steroids ☐ Oral immunosuppressants

☐ Topical calcineurin inhibitor ☐ Sinus surgery

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
Cibinqo™ (abrocitinib)	☐ 50mg tablets ☐ 100mg tablets ☐ 200mg tablets	Take one tablet by mouth once daily	Quantity _____ Refills _____

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.