Prescription & Enrollment Form

Gilotrif® (afatinib)

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 _____
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 wt obtained _____
❑ NKDA ❑ Known drug allergies _____
_____
Concurrent meds _____
_____

4 PRESCRIBING INFORMATION

The patient has tested positive for EGFR mutation: ❑ Yes ❑ No
The patient has squamous histology: ❑ Yes ❑ No

Medication	Strength/Formulation	Directions	Quantity/Refills
Gilotrif® (afatinib)	❑ 40mg tablet ❑ 30mg tablet ❑ 20mg tablet	❑ Take _____ tablet(s) daily. ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____

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

By your acknowledgement and signature above, an authorization is provided to dispense the prescription as written including a patient welcome kit with an associated supply of loperamide.

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.

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