**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
# Inflammatory Bowel Disease

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 _____
☐ Male ☐ Female Last 4 digits of SSN _____ Date of birth _____
Street address _____ Apt # _____
City _____ State _____ Zip _____
Home phone _____ Cell phone _____ E-mail address _____
Parent/guardian (if applicable) _____
Home phone _____ Cell phone _____ E-mail address _____
Alternate caregiver/contact _____
Home phone _____ Cell phone _____ E-mail 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 _____
**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 e-mail _____
Office street address _____ Suite # _____
City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below:
**Infusion info:** Infusion site name _____ Clinic/hospital affiliation _____
Site street address _____ Suite # _____
City _____ State _____ Zip _____
Infusion clinic contact name _____ Phone _____ E-mail _____

## 3 Clinical Information

**Primary ICD-10 code (REQUIRED):** _____ Rationale for therapy _____
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 _____ Height _____ in/cm BSA _____ m2
☐ 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 | Dose | Directions | Quantity/Refills |
|---|---|---|---|
| ☐ Simponi® (golimumab) | ☐ 100mg | ☐ Initial Dose: 200mg subcutaneously at week 0 followed by 100mg subcutaneously at 2 weeks<br>☐ Maintenance Dose: 100mg subcutaneously every 4 weeks | ☐ 1-month supply<br>☐ 3-month supply<br>☐ Other _____<br>Refills _____ |
| ☐ Xeljanz® (tofacitinib citrate) | ☐ 5mg tablets<br>☐ 10mg tablets | ☐ Take 10mg by mouth twice daily for 8 weeks, followed by 5mg twice daily<br>☐ Take 10mg by mouth twice daily<br>☐ Take 5mg by mouth twice daily<br>☐ Take 5mg by mouth once daily | ☐ 1-month supply<br>☐ 3-month supply<br>☐ Other _____<br>Refills _____ |
| ☐ Other | | | |
| **Ancillary Supplies: (Prescriber to strike through if not required)**<br>Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed. | | | Send quantity sufficient for medication days supply. |

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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