

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](http://MyAccredoPatients.com) to log in or get started.

Prescription & Enrollment Form  
**Pirfenidone**

**accredo**<sup>®</sup>  
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'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 \_\_\_\_\_

# 3 Clinical Information

Primary ICD-10 code (REQUIRED): \_\_\_\_\_

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
pirfenidone	Initial titration: 267mg tablets	Initial titration: Days 1-7: 1 tablet by mouth 3 times/day with meals Days 8-14: 2 tablets by mouth 3 times/day with meals Days 15+: 3 tablets by mouth 3 times/day with meals	1-month supply No refills
	Maintenance dose: 267mg tablets	Maintenance dose: 3 tablets by mouth 3 times/day with meals	1-month supply 3-month supply Other
	Maintenance dose: 801mg tablets	Maintenance dose: 1 tablet by mouth 3 times/day with meals Other _____	Refills _____
Other _____			1-month supply 3-month supply Other  Refills _____

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.