Prescription & Enrollment Form

Rheumatoid arthritis—Intravenous

accredo®

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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: _____
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 _____
❑ NKDA ❑ Known drug allergies _____
_____
Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Actemra® (tocilizumab)	❑ 4 mg/kg intravenous infusion every 4 weeks. Maximum dose of 800 mg/infusion ❑ 8 mg/kg intravenous infusion every 4 weeks. Maximum dose of 800 mg/infusion	Dilute desired dose with normal saline to a total volume of 100 mL to be infused over 1 hour.	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Orencia® (abatacept)	❑ 500 mg (less than 60 kg) ❑ 750 mg (60–100 kg) ❑ 1000 mg (over 100 kg) ❑ Juvenile arthritis 10 mg/kg if less than 75 kg **Starting dose:** ❑ at week: 0, 2 and 6, then every 4 weeks **Maintenance dose:** ❑ every 4 weeks	Reconstitute each vial of Orencia with 10 mL of sterile water. Dilute desired dose to total of 100 mL in normal saline to be infused over 30 minutes.	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Remicade® (infliximab) ❑ Inflectra® (infliximab-dyyb) ❑ Renflexis® (infliximab-abda)	**Starting dose:** ❑ 5 mg/kg _____ mg IV at week: 0, 2, 6 ❑ 3 mg/kg _____ mg IV at week: 0, 2, 6 ❑ Other _____ ❑ **Maintenance dose:** (_____ mg/kg) _____ mg IV every _____ weeks	Reconstitute each vial of Remicade with 10 mL of sterile water. Dilute desired dose to total of 250 mL in normal saline to be infused over a period NOT less than 2 hours.	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Simponi Aria® (golimumab)	**Starting dose:** ❑ 2 mg/kg _____ mg IV at week: 0, 4 and every 8 weeks ❑ Other _____ **Maintenance dose:** ❑ 2 mg/kg _____ mg IV every 8 weeks ❑ Other _____	Each 4 mL vial contains 50 mg of Simponi Aria. Dilute the total desired volume (based on 2 mg/kg dosing) of Simponi Aria with 0.9% sodium chloride to a total volume of 100 mL. Infuse diluted solution over a period of 30 minutes.	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Other _____ _____			❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____

Complete the below information if assistance from Accredo is requested in the coordination of your patient's infusion therapy.

Preferred infusion setting: ❑ Home ❑ Infusion clinic

Premedication orders
❑ Acetaminophen 650 mg PO 30 min prior to infusion ❑ Diphenhydramine 50 mg PO 30 min prior to infusion ❑ Hydrocortisone 100 mg IV PO 30 min prior to infusion
❑ Other _____

1-month supply
Refill x 1 year unless noted otherwise
❑ Other _____

Hypersensitivity/anaphylaxis orders ❑ Stop infusion ❑ Start normal saline at TKO

Medicate with:
❑ Epinephrine/EpiPen® 0.3 mg IM as needed for anaphylaxis. ❑ Diphenhydramine 50 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if there is no IV access.
❑ Hydrocortisone 100 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM in there is no IV access.
❑ Solumedrol 125 mg slow IVP PRN for urticaria, pruritis, SOB. Administer IM if there is no IV access.

1-month supply
Refill x 1 year unless noted otherwise
❑ Other _____

For anaphylactic reaction, activate 911. Notify physician of type reaction and action taken. Verbal report and transfer care to EMS, if applicable.

Flushing orders
❑ Peripheral access ❑ Central venous access ❑ 0.9% sodium chloride flush with _____ mL IV before and after medication and IVP for maintenance.
❑ Heparin _____ units per mL. Flush with _____ units as final flush and as directed.

1-month supply
Refill x 1 year unless noted otherwise
❑ Other _____

Lab orders _____
❑ Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. Dispense 1 month of drug, flushes, needles, syringes, ancillary supplies and medical equipment necessary to establish access and administer medication.

Prescription to include all necessary ancillary supplies (needles, syringes, etc.) 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

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 Accredo 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.