

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 Rheumatoid Arthritis – Oral

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'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): _____ 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 _____

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
Olumiant® (baricitinib)	2mg tablets	Take 2mg by mouth once a day	1-month supply Refill x1 year unless noted otherwise 3-month supply Refill x1 year unless noted otherwise Other _____ Refills _____
Rinvoq® (upadacitinib)	15mg tablets	Take 15mg by mouth once a day	1-month supply Refill x1 year unless noted otherwise 3-month supply Refill x1 year unless noted otherwise Other _____ Refills _____
Xeljanz® (Tofacitinib)	5mg tablets 11mg tablets XR 1mg/mL oral solution 240mL	Take 5mg by mouth twice a day Take 11mg by mouth once a day Take _____ mg by mouth twice a day	1-month supply Refill x1 year unless noted otherwise 3-month supply Refill x1 year unless noted otherwise Other _____ Refills _____
Other _____			

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.