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

Ulcerative Colitis

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 ______

Sex at birth: Male Female Pronouns ______ Last 4 digits of SSN ______ Date of birth ______

Street address ______ Apt # ______

City ______ State ______ Zip ______

Home phone ______ Cell phone ______ Email address ______

Parent/guardian (if applicable) ______

Home phone ______ Cell phone ______ Email address ______

Alternate caregiver/contact ______

Home phone ______ Cell phone ______ Email 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 ______

Office/clinic/institution name ______

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 email ______

Office street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion location: Patient's home Prescriber's office Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name ______ Clinic/hospital affiliation ______

Site street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion site contact ______ Phone ______ Fax ______ Email ______

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	Strength/Formulation	Directions	Quantity/Refills
Amjevita™ (adalimumab-atto) Citrate Free (ADULT)	40mg/0.8mL SureClick Autoinjector 40mg/0.8mL prefilled syringe (PFS)	**Starter dose:** Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose
		Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Other ________ Refills ________
Cyltezo® (adalimumab-adbm) Citrate Free (ADULT)	40mg/0.8mL pen 40mg/0.8mL PFS	**Starter dose:** Inject 160mg on day 1 --OR-- Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose
		Maintenance dose: Inject 40mg subcutaneously every other week	1-month supply 3-month supply Other ________ Refills ________
Humira® (adalimumab) (ADULT)	**Starter dose:** 80mg/0.8mL prefilled pen Starter Package (3 PENS) 40mg/0.8mL pens starter kit 40mg /0.4mL PFS for starter dose	160mg injected day 1 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1-month supply 3-month supply Other ________ Refills ________
	Maintenance dose: 40mg/0.4mL citrate-free pen 40mg/0.4mL citrate-free PFS 40mg/0.8mL pen 40mg/0.8mL PFS	Inject 40mg subcutaneously every other week.	
Humira® (adalimumab) (PEDIATRIC)	**Starter dose:** 80mg/0.8mL prefilled pen UC Starter Package (4 PENS) 40mg /0.4mL PFS for starter dose	160mg injected day 1 --OR-- 80mg injected each day 1 and day 2 then 80mg administered weekly for 2 weeks (a dose on day 8 and day 15) then maintenance dose starting on day 29.	1 STARTER KIT -OR- QS for 1-month loading dose
	40mg /0.4mL PFS for starter dose	80mg subcutaneously on day 1, then 40mg administered weekly for 2 weeks (a dose on day 8 and day 15) then maintenance dose starting on day 29.	
	Maintenance dose: 40mg/0.4mL citrate-free pen 40mg/0.4mL citrate-free PFS 40mg/0.8mL pen 40mg/0.8mL PFS 80mg/0.8mL citrate-free pen 20mg/0.2mL PFS	Inject 80mg subcutaneously every other week Inject 40mg subcutaneously every week Inject 40mg subcutaneously every other week Inject 20mg subcutaneously every week	1-month supply 3-month supply Other ________ Refills ________
Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

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.

Patient's first name ____________ Last name ____________ Middle initial ______ Date of birth ____________

Prescriber's first name ____________ Last name ____________ Phone ____________

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Simponi® (golimumab)	100mg/mL in each single-dose PFS	**Loading dose:** Inject 200mg subcutaneously at week 0, followed by 100mg subcutaneously at week 2	3 doses for loading/ induction
	100mg/mL in each single-dose pen	**Maintenance dose:** Inject 100mg subcutaneously every 4 weeks.	1-month supply 3-month supply Other ________ Refills ________
Stelara® (ustekinumab)	90mg/mL in each single-dose PFS	**Maintenance dose:** Inject 90mg subcutaneously every 8 weeks.	2-month supply Other ________ Refills ________
		Maintenance Dose Only Needed. If loading dose is needed, please see IV referral form. By selecting Stelara on this form, I am indicating that patient has already received/does not need IV loading dose at this time.	
Xeljanz®	5mg tablets 10mg tablets	**Loading dose:** Take 10mg by mouth twice daily for 8 weeks, followed by 5mg twice daily	QS for 2-month loading dose
		Maintenance dose: Take 10mg by mouth twice daily Take 5mg by mouth twice daily Take 5mg by mouth once daily	1-month supply 3-month supply Other ________ Refills ________
Xeljanz XR	11mg ER tablets 22mg ER tablets	**Loading dose:** 22mg once daily for at least 8 weeks, followed by 11mg once daily	QS for 2-month loading dose
		Maintenance dose: Take 11mg by mouth once daily	1-month supply 3-month supply Other ________ Refills ________
Zeposia® (ozanimod)	**Starter dose:** Starter Pack (28 day) Starter Pack (7 day)	Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule for 3 days, then one 0.92mg capsule daily thereafter	1 KIT
	Maintenance dose: 0.92mg capsules	Take one capsule daily	1-month supply 3-month supply Other ________ Refills ________
Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

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.

accredo®

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. All rights in the product names, trade names or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners. © 2023 Accredo Health Group, Inc. | An Express Scripts Company. All rights reserved. ULC-00001-H-090423 CRP2408_11609