Please fax all pages of completed form to your team at 888.302.1028.
To reach your team, call toll-free 844.516.3319.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Arthritis and Inflammatory—Intravenous

EVERNORTH HEALTH SERVICES

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 _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ 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 _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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

INFUSION LOCATION: ☐ Patient's home ☐ Healthcare facility

Medication	Strength/ Formulation	Directions	Fluids for administration and reconstitution (Please strike through if not required)	Quantity/Refills
☐ Actemra® (tocilizumab)	☐ 80mg/4mL single-dose vial (SDV) ☐ 200mg/ 10mL SDV ☐ 400mg/ 20mL SDV	Rheumatoid Arthritis (RA): ☐ 4mg/kg intravenous infusion every 4 weeks. Maximum dose of 800mg/infusion. ☐ 8mg/kg intravenous infusion every 4 weeks. Maximum dose of 800mg/infusion. Polyarticular Juvenile Idiopathic Arthritis (PJIA): ☐ 10mg/kg intravenous infusion every 4 weeks (2 years or older, less than 30kg) ☐ 8mg/kg intravenous infusion every 4 weeks (2 years or older, 30kg or greater) Systemic Juvenile Idiopathic Arthritis (SJIA) and Cytokine Release Syndrome: ☐ 12mg/kg intravenous infusion every 2 weeks (2 years or older, less than 30kg) Maximum dose of 800mg/infusion ☐ 8mg/kg intravenous infusion every 2 weeks (2 years or older, 30kg or greater) Maximum dose of 800mg/infusion	Dilute desired dose with normal saline to total desired volume to be infused over 1 hour. NS 0.9% 100mL >30kg NS 0.9% 50mL < 30kg	☐ 28-day supply ☐ 84-day supply Refill x 1 year unless noted otherwise ☐ Other _____ Refills _____
☐ Orencia® (abatacept)	☐ 250mg SDV	Rheumatoid Arthritis and Psoriatic Arthritis: ☐ 500mg (less than 60kg) intravenous infusion ☐ 750mg (60 to 100kg) intravenous infusion ☐ 1000mg (over 100kg) intravenous infusion Juvenile Idiopathic Arthritis: ☐ 10mg/kg intravenous infusion (if less than 75kg) ☐ 750mg intravenous infusion (75 to 100kg) ☐ 1,000mg intravenous infusion (over 100kg) ☐ **Loading dose:** at week 0, 2 and 4, then every 4 weeks ☐ **Maintenance dose:** every 4 weeks	Reconstitute each vial of Orencia with 10mL of sterile water. Dilute desired dose to total of 100mL in normal saline to be infused over 30 minutes. NS 0.9% 100mL Sterile Water as needed for reconstitution.	**Loading dose:** ☐ 3 doses No refills **Maintenance dose:** ☐ 28-day supply Refill x 1 year unless noted otherwise ☐ Other _____ Refills _____
☐ Simponi Aria® (golimumab)	☐ 50mg/ 4mL SDV	☐ **Loading dose:** 2mg/kg _____ mg IV at week 0, 4 and every 8 weeks ☐ Other _____ ☐ **Maintenance dose:** 2mg/kg _____ mg IV every 8 weeks ☐ Other _____	Dilute desired dose with normal saline to a total volume of 100mL to be infused over 30 minutes.	**Loading dose:** ☐ 3 doses No refills **Maintenance dose:** ☐ 56-day supply Refill x 1 year unless noted otherwise ☐ Other _____ Refills _____
☐ Other				

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

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 (cont.)

Required medication and supplies for home infusion (please complete this section for home infusions only)	
Premedication orders ☐ Acetaminophen 650mg PO 30 min prior to infusion ☐ Diphenhydramine 50mg PO 30 min prior to infusion ☐ Hydrocortisone 100mg IVP 30 min prior to infusion ☐ Other _____	Send quantity and refills sufficient for medication dose and days supply.
Infusion method: Gravity (Pediatric patients will be given a pump unless noted otherwise) ☐ Prefer Pump	
Flushing orders NS 0.9% Flush (if central venous access, sterile flush will be provided) Choose administration access: ☐ Peripheral access ☐ Central venous access If central venous access: Flush with 10mL Sterile NS 0.9% before and after infusion. ☐ Follow with heparin 100units/mL 5mL final flush If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed	
Hypersensitivity/Anaphylaxis Stop infusion **Medicate with**: Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis (for children less than 30kg: Epinephrine 0.15mg) ☐ Start NS 0.9% 100mL at TKO ☐ Diphenhydramine 50mg slow IVP PRN anaphylaxis ☐ Hydrocortisone 100mg slow IVP PRN anaphylaxis ☐ Methylprednisolone 125mg slow IVP PRN anaphylaxis ☐ Diphenhydramine 50mg PO PRN anaphylaxis ☐ Other _____	
☐ Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. *If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.	

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

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

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.

EVERNORTH HEALTH SERVICES

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