Please fax all pages of completed form to your team at 800.330.0756.
To reach your team, call toll-free 866.712.5200.
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

Bleeding disorders: Subcutaneous therapies

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.

Patient's first name _____ Last name _____ Middle initial _____
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) _____
☐ 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.

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 _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Bleeding disorder type: ☐ A ☐ B ☐ Other _____
Severity: ☐ Mild ☐ Moderate ☐ Severe Height _____ Weight _____ Date obtained _____
Inhibitor: ☐ No ☐ Yes (_____ B.U.) Target joint(s): ☐ No ☐ Yes Location _____
☐ NKDA ☐ Known drug allergies _____
Concurrent meds _____
Additional clinical information _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____

4 Prescribing Information

Subcutaneous prophylaxis orders—Complete this form OR attach prescription below.

Medication	Route	Strength/Formulation	Directions
☐ Alhemo®	SQ injection	☐ Loading dose: 1mg/kg	Month 1 with Loading dose: Inject 1mg/kg OR _____mg under the skin on day 1, then inject 0.2mg/kg OR _____mg once daily. Qty: 28-day supply No Refills
		☐ Maintenance dose: 0.2mg/kg ☐ Maintenance dose adjustment for ELISA test >4000ng/mL: 0.15mg/kg ☐ Maintenance dose adjustment for ELISA test <200ng/mL: 0.25mg/kg	Maintenance dose: ☐ Inject 0.2mg/kg OR _____mg under the skin once daily. ☐ Inject 0.15mg/kg OR _____mg under the skin once daily. ☐ Inject 0.25mg/kg OR _____mg under the skin once daily. Qty: 28-day supply Refills x 1 year unless otherwise noted here: _____
☐ Hemlibra®	SQ injection	☐ Loading dose: 3mg/kg	Loading dose: Inject 3mg/kg OR _____mg under the skin every 7 days. Qty: 28-day supply No Refills
		☐ Maintenance dose: ☐ 1.5mg/kg ☐ 3mg/kg ☐ 6mg/kg ☐ Other _____	Maintenance dose: Inject _____mg/kg OR _____mg under the skin every _____ days. Qty: 28-day supply Refills x 1 year unless otherwise noted here: _____
	☐ Check here if Accredo pharmacist is NOT authorized to round dose to the nearest full vial size/combination to minimize drug waste.		

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 _____

4 Prescribing Information (cont.)

Subcutaneous prophylaxis orders—Complete this form OR attach prescription below.

Medication	Route	Strength/Formulation	Directions
☐ Hympavzi™ (For Patients 12 Years of Age and Older)	SQ injection	☐ Loading dose: 300mg	Month 1 with Loading dose: Inject 300mg under the skin on day 1, then inject 150mg on day 8 and weekly thereafter. Qty: 28-day supply No Refills
		☐ Maintenance dose: 150mg	Maintenance dose: Inject 150mg under the skin every 7 days. Qty: 28-day supply Refills x 1 year unless otherwise noted here: _____
		☐ Maintenance dose adjustment: 300mg	Maintenance dose with dose adjustment: Inject 300mg under the skin every 7 days. Qty: 28-day supply Refills x 1 year unless otherwise noted here: _____
☐ Hympavzi™ (Pediatric Patients: Ages 6 to less than 12 years of Age)	SQ injection	☐ Loading dose: 150mg	Month 1 with Loading dose: Inject 150mg under the skin on day 1, then inject 75mg on day 8 and weekly thereafter. Qty: 28 day supply No Refills
		☐ Maintenance dose: 75mg	Maintenance dose: Inject 75mg under the skin every 7 days. Qty: 28-day supply Refills x 1 year unless otherwise noted here: _____
		☐ Maintenance dose adjustment: 150mg	Maintenance dose with dose adjustment: Inject 150mg under the skin every 7 days. Qty: 28-day supply Refills x 1 year unless otherwise noted here: _____

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 _____

4 Prescribing Information (cont.)

Clotting factor orders for breakthrough bleeding OR bypassing agent orders for breakthrough bleeding	
Clotting factor brand name: _____	Units/kg _____ Qty _____ Refills _____ Directions: Infuse _____ units (+/-10%) intravenously as needed for breakthrough bleeding. Other: _____
Bypassing agent brand name: _____	mcg/kg _____ Qty _____ Refills _____ Directions: Infuse _____ mcg/kg or _____ mg intravenously every _____ hours as needed for breakthrough bleeding. Other: _____
Ancillary medications/supplies/nursing	
☐ Aminocaproic Acid _____ mg tablets ☐ 500mg ☐ 1000mg tablets ☐ Oral solution 250mg/mL Directions _____	Qty _____ Frequency _____ Refills _____
☐ Tranexamic Acid 650mg tablets Directions _____	Qty _____ Frequency _____ Refills _____
☐ Emla® Apply topically as needed to IV site 60 minutes prior to insertion prn and cover with occlusive dressing.	Qty _____ Frequency _____ Refills _____
☐ LMX™ Apply topically as needed to IV site 30–60 minutes prior to insertion prn and cover with occlusive dressing.	Qty _____ Frequency _____ Refills _____
☐ Heparin _____ units/mL _____ flush Qty _____ Frequency _____ Refills _____	
☐ Normal Saline 0.9% Qty _____ Frequency _____ Refills _____	
☐ Other _____ Qty _____ Frequency _____ Refills _____	
☐ Skilled nursing visit to provide patient education related to therapy, disease state, self and/or nurse administer of medication as prescribed. Visit frequency based on prescriber medication and dosage orders.	
Supplies: (please strike through if not required) Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.	
Attach prescription form here.	

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.

EVERNORTH HEALTH SERVICES