**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

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):** _____ Bleeding disorder type: ☐ A ☐ B ☐ vWD ☐ Other _____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Type vWD _____

Height _____ Weight _____ Date obtained _____

IV access: ☐ PIV/butterfly ☐ PICC ☐ Implanted port ☐ Central line 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 _____ Phone _____

# 4 Prescribing Information

| **Clotting factor orders—Complete this form OR attach prescription below.** | | | | |
|---|---|---|---|---|
| Brand name _____ | Units/kg _____ | Qty _____ | Frequency _____ | Refills _____ |
| Brand name _____ | Units/kg _____ | Qty _____ | Frequency _____ | Refills _____ |
| Brand name _____ | Units/kg _____ | Qty _____ | Frequency _____ | Refills _____ |
| Mild Bleeding use: Units/kg _____ | Severe Bleeding use: Units/kg _____ | | | |
| Prophylaxis: Dispense _____ doses/week | Episodic: Dispense _____ doses for mild/_____ doses for severe | | | |

| **Ancillary medications/supplies/nursing** | |
|---|---|
| ☐ Aminocaproic Acid _____mg tablets<br>☐ 500mg ☐ 1000mg tablets ☐ Oral solutions 250mg/mL<br>Directions _____ | Qty _____ Frequency _____ Refills _____ |
| ☐ Desmopressin Acetate Solution 1.5mg/mL spray in:<br>☐ one nostril ☐ each nostril (2 sprays total) | Qty _____ Frequency _____ Refills _____ |
| ☐ Tranexamic Acid 650mg tablets<br>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 _____ | |
| ☐ Saline _____mL flush Qty _____ Frequency _____ Refills _____ | |
| ☐ Other _____ Qty _____ Frequency _____ Refills _____ | |
| ☐ Skilled nursing visits to be provided for infusions ☐ Skilled nursing visits to be provided for teaching | |
| ☐ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, infusion device, etc. to administer the therapy as needed. | |
| Attach prescription form here.<br><br>Refill x _____ | |

**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

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