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

HIV metabolic support

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 _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

3 Clinical Information

Primary ICD-10 code (REQUIRED): B20 Human immunodeficiency virus [HIV] disease ☐ R64 Cachexia (Serostim® only) ☐ E88.1 Lipodystrophy (Egrifta WR™ only)

Weight (kg) _____ Height (cm) _____ Date measured _____

BMI (kg/m^2) _____ Blood fasting glucose (mg/dL) _____ Waist circumference (cm) _____

Hip circumference (cm) _____ Waist-to-hip ratio (waist-to-hip ratio = waist circumference ÷ hip circumference) _____

Injection training needed: ☐ Yes ☐ No By: ☐ MD office ☐ Other _____ **If prior HgH use, date started** _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Please attach the following information for growth disorder diagnosis: Drug profile, labs, growth chart where applicable

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
☐ Egrifta WR™	11.6mg/vial medication box	☐ Inject 1.28mg (0.16mL) under the skin once daily ☐ Other	Dispense: ☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Serostim® (somatropin)	☐ 4mg multi-dose vial (MDV) with bacteriostatic water for injection ☐ 5mg single dose vial (SDV) with sterile water for injection ☐ 6mg SDV with sterile water for injection ☐ Alternate 4mg vial diluent: sterile water for injection (to use 4mg vial as single use)	Inject _____ mg under the skin once daily at bedtime	Dispense: ☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
Serostim ancillary supplies: Needle and Syringe: 3cc syringe, with 20G, 1" needles for reconstitution And one of the following for injection: ☐ 27G, 1/2" needles ☐ 29G, 1/2" needles ☐ 30G, 1/2" needles			Send quantity sufficient for medication days supply
☐ Other			

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

I certify that this medication is not being prescribed for anti-aging, cosmetic or athletic performance. I further certify human growth hormone is being prescribed for the medical condition noted above and is medically necessary.

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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