Please fax all pages of completed form to your team at 866.233.7151.
To reach your team, call toll-free 866.820.4844.
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

Lysosomal Storage Disorders (LSD)

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 _____

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) _____

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 # _____

3 Clinical Information

☐ Naive to therapy ☐ Currently on therapy

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

Infusion info: Infusion site name _____

CHECK ONE

☐ D84.1 Defects in the complement system ☐ E74.02 Pompe disease ☐ E75.21 Fabry disease ☐ E75.22 Gaucher disease
☐ E75.240 Niemann-Pick disease type A ☐ E75.241 Niemann-Pick disease type B ☐ E75.242 Niemann-Pick disease type C
☐ E75.244 Niemann-Pick disease type A/B ☐ E75.248 Other Niemann-Pick disease ☐ E75.249 Niemann-Pick disease, unspecified (NOS)
☐ E75.5 Other lipid storage disorders ☐ E76.0 Mucopolysaccharidosis I (MPS I) ☐ E76.01 Hurler's Syndrome
☐ E76.1 Hunter Syndrome (MPS II) ☐ E76.210 Morquio A syndrome (MPS IVA) ☐ E76.22 Sanfilippo mucopolysaccharidoses
☐ E76.29 Other mucopolysaccharidoses ☐ E76.3 Mucopolysaccharidosis, unspecified
☐ **Other** _____

Weight _____ kg/lbs Height _____ cm/in Date recorded _____

☐ NKDA ☐ Known drug allergies _____

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

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Directions

CHECK ONE

- ☐ ALDURAZYME® 2.9mg/5mL vial
- ☐ CERDELGA® 84mg capsule
- ☐ CEREZYME® 400 unit vial
- ☐ ELAPRASE® 2mg/mL vial
- ☐ ELELYSO® 200 unit vial
- ☐ ELFABRIO® 5mg or 20mg vial
- ☐ FABRAZYME® 5mg or 35mg vial
- ☐ KANUMA® 20mg/10mL vial
- ☐ LUMIZYME® 50mg vial
- ☐ MIGLUSTAT* 100mg capsule
- ☐ NEXVIAZYME® 100mg vial
- ☐ OPFOLDA™ 65mg capsule***
- ☐ POMBILITI™ 105mg vial***
- ☐ VPRIV® 400 unit vial
- ☐ XENPOZYME™ 4mg or 20mg vial**
- ☐ Other

Mandated HUB Medications

- ☐ GALAFOLD® 123mg capsule
  Fax mandatory hub form to 833.264.2873.
- ☐ MEPSEVII® 10mg/5mL vial
  Fax mandatory hub form to 415.723.7474.
- ☐ NAGLAZYME® 5mg/5mL vial
  Fax mandatory hub form to 888.863.3361.
- ☐ VIMIZIM® 1mg/mL vial
  Fax mandatory hub form to 888.863.3361.

Infuse _____ mg or _____ units intravenously every _____ week(s) OR Infuse _____ mg/kg or _____ units/kg. (where clinically appropriate, round to the nearest vial size)

OR Take _____ tablet/capsules by mouth _____ times per day

Rate protocol:
Titrate initial and maintenance infusions per manufacturer's product labeling.

Vascular access:
☐ Peripheral
☐ Central
☐ Port

Infusion method:
☐ Gravity ☐ Pump

*You must note the name of the brand product if brand is medically necessary for your patient _____

**Adult and pediatric titration dosing can be found in the Xenpozyme Package Insert

***Opfolda to be taken approximately 1 hour prior to Pombiliti infusion. Dosing can be found in the Package Insert.

All medications requiring reconstitution and/or dilution will be prepared according to manufacturer guidelines.

☐ Other instructions _____

☐ **Premedication to be given 30 minutes prior to infusion:** *(please check box to the left if desired to be included with order)*

- Diphenhydramine 25mg by mouth for mild infusion reactions, may increase to 50mg for history of moderate to severe
- Acetaminophen 650mg by mouth
- MPS Patients: Cetirizine 10mg once a day unless prescribed on age (see below)

☐ Other _____

For patients weighing less than 60kg, the following weight-based dosing range will be used: Acetaminophen: 10–15mg/kg

For pediatric patients, the following weight- and age-based dosing range will be used:

≤9kg and/or <2 years old: Diphenhydramine 1mg/kg up to max of 6.25mg

2–5 years old and >9kg: Diphenhydramine 6.25mg to 12.5mg

6–12 years old: Diphenhydramine 12.5 to 25mg

MPS patients: Ceritzine: 2-6 years old 2.5mg once daily; adults and children >6 y/o 5mg once a day

☐ **Medications to be used as needed:** *(please check box to the left if desired to be included with order)*

- Diphenhydramine 25mg by mouth every 4–6 hours as needed for mild infusion reactions, may increase to 50mg for moderate to severe; maximum of 4 doses per day
- Lidocaine 4% applied topically to insertion site prior to needle insertion as needed to prevent site pain
- Acetaminophen 650mg by mouth every 4–6 hours as needed for fever, headache or chills; maximum of 4 doses per day
- MPS patients: Ceritzine: 2-6 years old 2.5mg once daily; adults and children >6 y/o 5mg for mild symptoms and may use 10mg for severe symptoms

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.)

Medication	Directions
Adverse Reaction medications: *(keep on hand at all times)* • Epinephrine 0.3mg auto-injector 2-pk for patients weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose • Epinephrine 0.15mg auto-injector 2-pk for patients weighing less than 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose • Diphenhydramine 25mg by mouth for mild allergic reactions and 50mg for moderate to severe • Normal Saline 500mL bolus administered intravenously for allergic reaction/anaphylaxis, infuse wide open up to a max rate of 250mL per hour as tolerated by the patient (when required by manufacturer).	
Flushing orders: • 0.9% Normal Saline or Dextrose 5% (as required per manufacturer) 3mL intravenous (peripheral line) or 10mL intravenous (central line) before and after infusion, or as needed for line patency • Heparin 10 units per mL 3mL intravenous (peripheral line) as needed for final flush • Heparin 100 units per mL 5mL intravenous (central line) as needed for final flush • Additional orders: may flush with 20mL Normal Saline post infusion to clear drug from line	
Supplies: *(please strike through if not required)* Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.	
Quantity/Refills: Dispense 1 month supply. Refill x 1 year unless noted otherwise. ☐ Dispense 90 day supply. Refill x 1 year unless noted otherwise. ☐ Other _____	
Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.	

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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