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.

Prescription & Enrollment Form

Nemluvio® (nemolizumab-ilto)

accredo®

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: 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): _____

☐ NKDA ☐ Known drug allergies _____

Prior anaphylactic reaction: ☐ No ☐ Yes (Reason/date _____)

Concurrent meds _____

Patient wt _____ kg Date wt obtained _____ Prescription type: ☐ Naïve/new start ☐ Restart ☐ Continued therapy

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

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation and Directions	Quantity/Refills
☐ Nemluvio® (nemolizumab-ilto) 30mg/0.49mL single dose dual chamber pen	☐ **Starter Dose:** Inject 60mg under the skin on Day 1 then 30mg every 4 weeks starting on day 29 and thereafter. ☐ **Maintenance Dose:** Inject 30mg under the skin every 4 weeks. ☐ **Maintenance Dose:** Inject 30mg under the skin every 8 weeks. ☐ **Starter Dose:** Inject 60mg under the skin on Day 1 then 60mg every 4 weeks starting on day 29 and thereafter. ☐ **Maintenance Dose:** Inject 60mg under the skin every 4 weeks.	**Starter Dose:** 2 pens No refills **Maintenance Dose:** ☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____ Patient weight _____ kg

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.

accredo®

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. All rights in the product names, trade names or logos of all third-party products that appear this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners. © 2025 Accredo Health Group, Inc. I An Express Scripts Company. All rights reserved. AST-00008-031025 CRP1413703