

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

Neutropenia

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) _____ **PRIMARY DIAGNOSIS** _____

Current weight _____ kg/lbs Height _____ inches/cm BSA _____ m² Date measured _____

Laboratory results: WBC _____ cell/mm³ ANC _____ cell/mm³ Platelets _____ cell/mm³

Date _____ Date _____ Date _____

EXPECTED DATE OF FIRST/NEXT INJECTION _____ **DATE OF LAST INJECTION (if applicable)** _____

Agency nurse to visit home for injection: Yes No

Agency name and phone _____

NKDA Known drug allergies _____

Concurrent meds _____

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
Granix® (tbo-filgrastim)	300mcg/mL vial 300mcg/0.5mL prefilled syringe 480mcg/0.8mL prefilled syringe	Inject _____ mcg subcutaneously Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) Please include cycle.	Quantity _____ Days supply _____ Refills _____
Leukine® (sargramostim) lyophilized powder	250mcg vial	Inject _____ mcg IV SC Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) Please include cycle.	Quantity _____ Days supply _____ Refills _____
Fulphila® (pegfilgrastim-jmdb) Neulasta® (pegfilgrastim) Nyvepria® (pegfilgrastim-apgf) Stimufend® (pegfilgrastim-fpgk) Udenyca® (pegfilgrastim-cbqv) Ziextenzo™ (pegfilgrastim-bmez)	6mg/0.6mL prefilled syringe	Inject _____ mg subcutaneously Dosing directions (include post chemo directions, cyclic, one-time, duration of therapy, etc.) Please include cycle.	Quantity _____ Days supply _____ Refills _____
Neulasta® Onpro (pegfilgrastim) Udenyca® (pegfilgrastim-cbqv) Onbody	6mg/0.6mL subcutaneous prefilled syringe kit	To be applied by health care professional. Apply kit on skin to inject 6mg under the skin every _____ days as directed	Quantity _____ Days supply _____ Refills _____
Neupogen® (filgrastim) Nivestym™ (filgrastim-aafi)	300mcg/mL vial 480mcg/1.6mL vial	Inject _____ mcg IV SC Other _____ Dosing directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.) Please include cycle.	Quantity _____ Days supply _____ Refills _____
Neupogen® (filgrastim) Nivestym™ (filgrastim-aafi) Releuko® (filgrastim-ayow) Zarxio™ (filgrastim-sndz)	300mcg/0.5mL prefilled syringe 480mcg/0.8mL prefilled syringe		
Other _____			
Supplies (if needed per dose): 1mL syringe 22G 1" mixing needle 25G 5/8" admin. needle 3mL syringe Sterile water 10mL 27 1/2G 5/8" admin. needle (pediatrics only)			Send quantity sufficient for medication days supply
Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy		As needed for administration	Send quantity sufficient for medication days supply

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.