Please fax all pages of completed form to your Oncology 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

Oncology (oral) (E–S)

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'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): _____

Weight _____ kg/lbs Height _____ cm/in BSA _____ m^2 Date recorded _____

☐ 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
☐ Erleada® (apalutamide)	☐ 60mg tablets ☐ 240mg tablet	☐ 240mg (four 60mg tablets) orally once daily ☐ 240mg (1 tablet) orally once daily ☐ Other _____	Quantity _____ Days supply _____ Refills _____
☐ Faslodex® (fulvestrant)	☐ 250mg/5mL prefilled syringe	☐ Inject 500mg IM on days 1, 15, 29 and once monthly thereafter ☐ Other _____	Quantity _____ Refills _____
☐ Ibrance® (palbociclib)	☐ 75mg capsules ☐ 100mg capsules ☐ 125mg capsule ☐ 75mg tablets ☐ 100mg tablets ☐ 125mg tablets	☐ Take _____ mg orally daily for 21 days, followed by 7 days off ☐ Other _____	☐ 28-day supply ☐ Other _____ Refills _____
☐ Itovebi® (inavolisib)	☐ 3mg tablet ☐ 9mg tablet	☐ Take _____ mg orally daily ☐ Other _____	☐ 30-day supply ☐ Other _____ Refills _____
☐ Lorbrena® (lorlatinib)	☐ 25mg tablet ☐ 100mg tablet	☐ Take _____ mg orally once daily ☐ Other _____	Quantity _____ Days supply _____ Refills _____
☐ Promacta® (eltrombopag)	☐ 12.5mg Powder for Suspension ☐ 25mg Powder for Suspension ☐ 12.5mg tablet ☐ 25mg tablet ☐ 50mg tablet ☐ 75mg tablet	☐ Take _____ mg orally once daily ☐ Other _____	Quantity _____ Days supply _____ Refills _____
☐ dasatinib	☐ 20mg tablet ☐ 50mg tablet ☐ 70mg tablet ☐ 80mg tablet ☐ 100mg tablet ☐ 140mg tablet	☐ Take one tablet orally daily ☐ Other _____	Quantity _____ Days supply _____ Refills _____
☐ sunitinib malate	☐ 12.5mg capsule ☐ 25mg capsule ☐ 37.5mg capsule ☐ 50mg capsule	☐ Take one capsule orally daily continuously ☐ Take one capsule orally daily 4 weeks on and 2 weeks off ☐ Other _____	Quantity _____ Days supply _____ Refills _____
☐ Other _____	_____	_____	Quantity _____ Days supply _____ Refills _____

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.

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