

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.

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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 _____ m² 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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