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

Oncology

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 _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Cancer Stage (if applicable) _____

Weight (kg)* _____ Height (cm)* _____ Date measured _____ Body Surface Area (BSA)* _____ m^2

☐ NKDA ☐ Known drug allergies _____

Concurrent Medications (including combination oncology therapies, if applicable):

_____

For female patients, please indicate if any of the following applies: ☐ Pregnant ☐ Breastfeeding

*Required only when therapy dosing is dependent on patient-specific measurements.

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

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

☐ New Therapy ☐ Restart ☐ Change of Therapy Regimen From: _____

Medication	Strength/Formulation	Directions	Quantity/Refills
		Cycle (if applicable): _____	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
		Cycle (if applicable): _____	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
		Cycle (if applicable): _____	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
		Cycle (if applicable): _____	☐ 1-month supply ☐ 3-month supply ☐ Other Refills
Dispense ancillary supplies such as needle, syringes, sterile water, etc. to administer the therapy (strike through if not required)		As needed for administration	Send quantity sufficient for medication days supply

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.

EVERNORTH HEALTH SERVICES

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