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

Psoriasis

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): _____ Severity: ☐ Moderate ☐ Moderate to severe ☐ Severe ☐ BSA _____%

Type: ☐ Plaque ☐ Other _____

Significant symptoms _____

Prior Treatments: ☐ Topicals ☐ PUVA ☐ UVB ☐ Methotrexate ☐ Cyclosporine ☐ Oral retinoid ☐ Other _____

Medical justification for prescribing _____

☐ 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
☐ Bimzelx® (bimekizumab-bkzx)	☐ 160mg prefilled syringe (PFS) ☐ 160mg autoinjector ☐ 320mg PFS ☐ 320mg pen	**Loading dose:** ☐ 320mg (given as two 160mg injections) at Weeks 0, 4, 8, 12, and 16, then every 8 weeks thereafter. ☐ Patient does not need loading dose. Date(s) load administered _____ ☐ Patient needs partial loading dose. Please indicate what is needed: _____	QS for 1-month 4 Refills
		Maintenance dose: ☐ Inject 320mg subcutaneously every 8 weeks. ☐ Inject 320mg subcutaneously every 4 weeks (for patients weighing ≥ 120kg) ☐ Inject 160mg subcutaneously every 4 weeks	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Cimzia® (certolizumab)	☐ 200mg/mL PFS ☐ 200mg/mL lyophilized powder in single-dose vial for reconstitution	**Loading dose:** ☐ Inject 400mg subcutaneously at weeks 0, 2 and 4.	1 starter kit OR- QS for 1-month loading dose No Refills
		Maintenance dose: ☐ Inject 400mg subcutaneously every 2 weeks. ☐ Inject 200mg subcutaneously every 2 weeks. ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Cosentyx® (secukinumab)	☐ 75mg PFS ☐ 150mg PFS ☐ 150mg pen ☐ 300mg (2x150mg) PFS ☐ 300mg (2x150mg) pen ☐ 300mg unoready pen	**Loading dose:** ☐ Inject _____ mg subcutaneously at weeks 0, 1, 2, 3 and 4 followed by _____ every 4 weeks.	QS for 5 doses No Refills
		Maintenance dose: ☐ Inject _____ mg subcutaneously every 4 weeks.	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Enbrel® (etanercept)	☐ 25mg single-use vial ☐ 25mg PFS ☐ 50mg PFS ☐ 50mg SureClick™ ☐ 50mg mini cartridge	**Loading dose:** ☐ Inject 50mg subcutaneously twice a week x 3 months, then 50mg once a week.	QS for 3-month loading dose No Refills
		Maintenance dose: ☐ Inject 50mg subcutaneously once a week. ☐ Inject _____ mg subcutaneously _____ per week.	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other _____			
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			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.
By signing below, I certify that the above therapy is medically necessary.

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.

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
☐ Ilumya™ (tildrakizumab-asmn)	100mg/mL in a single-dose PFS	**Loading dose:** ☐ Inject 100mg subcutaneously at weeks 0, 4 and every 12 weeks thereafter.	2 syringes for loading/induction dose No Refills
		Maintenance dose: ☐ Inject 100mg subcutaneously every 12 weeks.	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Otezla® (apremilast)	☐ Starter Pack 10/20/30mg (28 day) ☐ Starter Pack 10/20mg (28 day)	**Loading dose:** TAKE AS DIRECTED BY PRESCRIBER OR PACKAGE INSTRUCTIONS.	1 Pack No Refills
	☐ 30mg tablets ☐ 20mg tablets	**Maintenance dose:** ☐ Take 30mg by mouth twice a day. ☐ Take 30mg by mouth once a day (severe renal impairment). ☐ Take 20mg by mouth twice a day.	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Siliq™ (brodalumab)	210mg/1.5mL PFS (2-pack)	**Loading dose:** ☐ Inject 210mg subcutaneously at weeks 0, 1 and 2 followed by 210mg every 2 weeks.	2 Packs No Refills
		Maintenance dose: ☐ Inject 210mg subcutaneously every 2 weeks.	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Skyrizi™ (risankizumab-rzaa)	☐ 150mg/mL in each single-dose PFS ☐ 150mg/mL in each single-dose pen	**Loading dose:** ☐ Inject 150mg subcutaneously at weeks 0, 4 and every 12 weeks thereafter.	2 doses for loading/induction No Refills
		Maintenance dose: ☐ Inject 150mg subcutaneously every 12 weeks.	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other _____			
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			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.

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
☐ Sotyktu™ (deucravacitinib)	6mg tablet	Take 1 tablet daily	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Stelara® (ustekinumab)	☐ 45mg/0.5mL single-dose vial ☐ 45mg/0.5mL PFS ☐ 90mg/1mL PFS Please include patient weight: _____ kg	**Loading dose:** ☐ Inject _____ mg subcutaneously at week 0 and week 4, followed by every 12 weeks thereafter	2 doses for loading/induction No Refills
		Maintenance dose: ☐ Inject _____ mg subcutaneously every 12 weeks	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Taltz® (ixekizumab)	☐ 80mg single-dose autoinjector ☐ 80mg single-dose PFS	**Loading and Induction dose:** ☐ Inject 160mg (two 80mg injections) subcutaneously at week 0, followed by 80mg at weeks 2, 4, 6, 8, 10 and 12, then 80mg every 4 weeks.	8 devices for loading/induction No Refills
		Maintenance dose: ☐ Inject 80mg subcutaneously every 4 weeks	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Tremfya™ (guselkumab)	☐ 100mg/mL in each single-dose PFS ☐ 100mg/mL in each single-dose pen	**Loading dose:** ☐ Inject 100mg subcutaneously at weeks 0, 4 and every 8 weeks thereafter.	2 doses for loading/induction No Refills
		Maintenance dose: ☐ Inject 100mg subcutaneously every 8 weeks.	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other _____			
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			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.

EVERNORTH HEALTH SERVICES

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