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

Rinvoq® (upadacitinib)

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'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): _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Patient weight _____ Date weight taken _____

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
☐ Rinvoq® (upadacitinib) Atopic Dermatitis	☐ 15mg extended release tablet	Take 1 tablet (15mg) once daily	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
	☐ 30mg extended release tablet	Take 1 tablet (30mg) once daily (inadequate response to 15mg dose)	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Rinvoq® (upadacitinib) Psoriatic Arthritis Rheumatoid Arthritis Ankylosing Spondylitis Non-radiographic Axial Spondyloarthritis Giant Cell Arteritis	15mg extended release tablet	Take 1 tablet once daily	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Rinvoq® (upadacitinib) Ulcerative Colitis	☐ 45mg extended release tablet	Loading Dose Take 1 tablet (45mg) once daily for 8 weeks	1-month supply (28 ct bottle) Refills _____
	☐ 15mg extended release tablet ☐ 30mg extended release tablet	Maintenance Dose ☐ Take 1 tablet (15mg) once daily ☐ Take 1 tablet (30mg) once daily (for patients with refractory, severe, or extensive disease)	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Rinvoq® (upadacitinib) Crohn's Disease	☐ 45mg extended release tablet	Loading Dose Take 1 tablet (45mg) once daily for 12 weeks	☐ 1-month supply (28 ct bottle) Refills _____
	☐ 15mg extended release tablet ☐ 30mg extended release tablet	Maintenance Dose ☐ Take 1 tablet (15mg) once daily ☐ Take 1 tablet (30mg) once daily (for patients with refractory, severe, or extensive disease)	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Rinvoq® LQ (upadacitinib) Polyarticular Juvenile Idiopathic Arthritis Pediatric Psoriatic Arthritis	1mg/mL oral solution	☐ 3mg (3mL oral solution) twice daily ☐ 4mg (4mL oral solution) twice daily ☐ 6mg (6mL oral solution) twice daily	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Other			

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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