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

Autosomal Dominant Polycystic Kidney Disease

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): Q61.2 Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No Please list all therapies tried/failed: _____

_____

Patient wt _____ Date wt obtained _____

☐ 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
☐ tolvaptan (generic to Jynarque®)	**Prescriber:** Select dose level, duration, and whether dose is part of initial titration and/or maintenance. Dispense quantity indicated up to 1-month supply per tolvaptan REMS dispensing limit. Each blister card = 7-days supply (14 tablets) **Additional special instructions:** _____		
	Standard dosing ☐ 45mg and 15mg tablet blister card ☐ 60mg and 30mg tablet blister card ☐ 90mg and 30mg tablet blister card	☐ Take one 45mg tablet by mouth upon waking, and one 15mg tablet 8 hours later for: ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ Titration ☐ Maintenance	Refills _____
		☐ Take one 60mg tablet by mouth upon waking, and one 30mg tablet 8 hours later for: ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ Titration ☐ Maintenance	Refills _____
		☐ Take one 90mg tablet by mouth upon waking, and one 30mg tablet 8 hours later for: ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ Titration ☐ Maintenance	Refills _____
	Adjusted dosing* ☐ 15mg and 15mg tablet blister card ☐ 30mg and 15mg tablet blister card ☐ 45mg and 15mg tablet blister card	☐ Take one 15mg tablet by mouth upon waking, and one 15mg tablet 8 hours later for: ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ Titration ☐ Maintenance	Refills _____
		☐ Take one 30mg tablet by mouth upon waking, and one 15mg tablet 8 hours later for: ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ Titration ☐ Maintenance	Refills _____
	**See package insert for dose adjustment for patients taking moderate CYP 3A Inhibitors. Tolvaptan is contraindicated with strong CYP 3A inhibitors.*	☐ Take one 45mg tablet by mouth upon waking, and one 15mg tablet 8 hours later for: ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ Titration ☐ Maintenance	Refills _____
☐ Other _____			

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