**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

# Tremfya®

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):** ____ 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 |
|---|---|---|---|
| Tremfya®<br>Patient weight is requested for pediatric patients:<br>______ kg | **Psoriasis and Psoriatic Arthritis** | | |
| | 100mg/mL in each single-dose One-Press injector<br>100mg/mL in each single-dose prefilled syringe (PFS) | Loading Dose:<br>Inject 100mg subcutaneously at weeks 0, 4 and every 8 weeks thereafter<br>Patient does not need loading dose. Date(s) load administered ______<br>Patient needs partial loading dose. Please indicate what is needed: ______ | QS for loading period<br>No Refills |
| | | Maintenance Dose:<br>Inject 100mg subcutaneously every 8 weeks | 1-month supply<br>3-month supply<br>Other ______<br>Refills ______ |
| | **Ulcerative Colitis** | | |
| | Loading:<br>200mg/20mL single-dose vial<br>200mg/2mL starter pack pen | Loading Dose:<br>Infuse 200mg IV at weeks 0, 4 and 8<br>Inject 400mg (2–200mg/2mL) subcutaneously at weeks 0, 4 and 8 | QS for loading period<br>No Refills |
| | Maintenance:<br>100mg/mL in each single-dose One-Press injector<br>100mg/mL in each single-dose PFS<br>100mg/mL in each single-dose pen<br>200mg/2mL in each single-dose PFS<br>200mg/2mL in each single-dose pen | Maintenance Dose:<br>Inject 100mg subcutaneously at week 16 and every 8 weeks thereafter<br>Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter<br>Inject 100mg subcutaneously every 8 weeks<br>Inject 200mg subcutaneously every 4 weeks | 1-month supply<br>3-month supply<br>Other ______<br>Refills ______ |
| | **Crohn's** | | |
| | Loading:<br>200mg/20mL single-dose vial<br>200mg/2mL starter pack pen | Loading Dose:<br>Infuse 200mg IV at weeks 0, 4 and 8<br>Inject 400mg (2-200mg/2mL) subcutaneously at weeks 0, 4 and 8 | QS for loading period<br>No Refills |
| | Maintenance:<br>100mg/mL in each single-dose One-Press injector<br>100mg/mL in each single-dose PFS<br>100mg/mL in each single-dose pen<br>200mg/2mL in each single-dose PFS<br>200mg/2mL in each single-dose pen | Maintenance Dose:<br>Inject 100mg subcutaneously at week 16 and every 8 weeks thereafter<br>Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter<br>Inject 100mg subcutaneously every 8 weeks<br>Inject 200mg subcutaneously every 4 weeks | 1-month supply<br>3-month supply<br>Other ______<br>Refills ______ |
| Other | | | |

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
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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