Please fax both 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.

Prescription & Enrollment Form

Arthritis and Inflammatory — Subcutaneous

accredo®

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 _____

☐ Male ☐ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

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 e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion clinic contact name _____ Phone _____ E-mail _____

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	Dose/Directions	Quantity/Refills
☐ Actemra® (tocilizumab)	Rheumatoid Arthritis (RA): ☐ 162mg subcutaneously once every week (greater than or equal to 100kg) ☐ 162mg subcutaneously every other week (less than 100kg) Polyarticular Juvenile Idiopathic Arthritis (PJIA): ☐ 162mg/dose subcutaneously once every 3 weeks (2 years or older, Less than 30kg) ☐ 162mg/dose subcutaneously once every 2 weeks (2 years or older, 30kg or greater) Systemic Juvenile Idiopathic Arthritis (SJIA): ☐ 162mg/dose subcutaneously once every 2 weeks. (2 years or older, Less than 30kg) ☐ 162mg/dose subcutaneously once every week. (2 years or older, 30kg or greater) Giant cell arteritis: ☐ 162mg subcutaneously once every week	☐ 1-month supply. Refill x 1 year unless noted otherwise. ☐ 90-day supply. Refill x 1 year unless noted otherwise. ☐ Other _____ Refills _____
☐ Orencia® (abatacept)	Rheumatoid Arthritis (RA): ☐ 125mg subcutaneously once weekly Juvenile idiopathic arthritis: ☐ 50mg subcutaneously once weekly (2 years and older and weighing 10kg to less than 25kg) ☐ 87.5mg subcutaneously once weekly (weight 25kg to less than 50kg) ☐ 125mg subcutaneously once weekly (weight greater than or equal to 50kg)	☐ 1-month supply. Refill x 1 year unless noted otherwise. ☐ 90-day supply. Refill x 1 year unless noted otherwise. ☐ Other _____ Refills _____
☐ Simponi® (golimumab)	☐ 50mg subcutaneously once per month	☐ 1-month supply. Refill x 1 year unless noted otherwise. ☐ 90-day supply. Refill x 1 year unless noted otherwise. ☐ Other _____ Refills _____
☐ Other _____		☐ 1-month supply. Refill x 1 year unless noted otherwise. ☐ 90-day supply. Refill x 1 year unless noted otherwise. ☐ Other _____ Refills _____

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.

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