Please fax both pages of completed form to your team at 800.330.0756.
To reach your team, call toll-free 866.712.5200.
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

Bleeding disorders

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 ______

Sex at birth: ❑ Male ❑ Female Preferred pronouns ____________ 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 ____________

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 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 dotted line:

- -

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

Site street address ____________ Suite # ______

City ____________ State ____________ Zip ____________

Infusion site contact ____________ Phone ____________ Fax ____________ E-mail ____________

3 Clinical Information

Primary ICD-10 code (REQUIRED): ____________ Bleeding disorder type: ❑ A ❑ B ❑ vWD ❑ Other ____________

Severity: ❑ Mild ❑ Moderate ❑ Severe ❑ Type vWD ____________

Height ____________ Weight ____________ Date obtained ____________

IV access: ❑ PIV/butterfly ❑ PICC ❑ Implanted port ❑ Central line Inhibitor: ❑ No ❑ Yes (____________ B.U.)

Target joint(s): ❑ No ❑ Yes Location ____________ ❑ NKDA ❑ Known drug allergies ____________

Concurrent meds ____________

Additional clinical information ____________

Patient's first name ______________________ Last name _________________________ Middle initial ______ Date of birth _________

Prescriber's first name ______________________________ Last name ________________________________ Phone ________________

4 Prescribing Information

Clotting factor orders—Complete this form OR attach prescription below.				
Brand name	Units/kg	Qty	Frequency	Refills
Brand name	Units/kg	Qty	Frequency	Refills
Brand name	Units/kg	Qty	Frequency	Refills
Mild Bleeding use: Units/kg	Severe Bleeding use: Units/kg			
Prophylaxis: Dispense _______________ doses/week	Episodic: Dispense __________ doses for mild/_________ doses for severe			

Ancillary medications/supplies/nursing	
❑ Aminocaproic Acid ________ mg tablets ❑ 500mg ❑ 1000mg tablets ❑ Oral solutions 250mg/mL Directions ____	Qty ___________ Frequency ______________ Refills ______________
❑ Desmopressin Acetate Solution 1.5mg/mL spray in: ❑ one nostril ❑ each nostril (2 sprays total)	Qty ___________ Frequency ______________ Refills ______________
❑ Tranexamic Acid 650mg tablets Directions ____	Qty ___________ Frequency ______________ Refills ______________
❑ Emla® Apply topically as needed to IV site 60 minutes prior to insertion prn and cover with occlusive dressing.	Qty ___________ Frequency ______________ Refills ______________
❑ LMX™ Apply topically as needed to IV site 30–60 minutes prior to insertion prn and cover with occlusive dressing.	Qty ___________ Frequency ______________ Refills ______________
❑ Heparin __________ units/mL __________ mL flush Qty ___________ Frequency ______________ Refills ______________	
❑ Saline ____________ mL flush Qty ___________ Frequency ______________ Refills ______________	
❑ Other ____ Qty ___________ Frequency ______________ Refills ______________	
❑ Skilled nursing visits to be provided for infusions ❑ Skilled nursing visits to be provided for teaching	
❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, infusion device, etc. to administer the therapy as needed.	
Attach prescription form here. Refill x ________________________________	

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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