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
Crohn's Disease

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
☐ Cimzia® (certolizumab)	**Starter**: ☐ 200mg/mL solution in a single-dose PFS Starter Kit ☐ 200mg/mL lyophilized powder in a single-dose vial for reconstitution	Inject 400mg subcutaneously at weeks 0, 2 and 4	1 STARTER KIT -OR- QS for full loading dose
	Maintenance: ☐ 200mg/mL solution in a single-dose prefilled syringe (PFS) ☐ 200mg/mL lyophilized powder in a single-dose vial for reconstitution	Inject 400mg subcutaneously every 4 weeks	☐ 1-month supply ☐ 3-month supply ☐ Other _____ ☐ Refills _____
☐ Humira® (adalimumab) (ADULT)	**Starter**: ☐ 80mg/0.8mL Pre-Filled Pen Starter Package (3 PENS) ☐ 40mg/0.8mL pens starter kit ☐ 40mg /0.4mL prefilled syringes for starter dose	☐ 160mg injected day 1 --OR-- ☐ 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1 STARTER KIT -OR- QS for 1 month loading dose
	Maintenance: ☐ 40mg/0.4mL citrate-free pen ☐ 40mg/0.8mL pen ☐ 40mg/0.4mL citrate-free PFS ☐ 40mg/0.8mL PFS	Inject 40mg subcutaneousy every other week	☐ 1-month supply ☐ 3-month supply ☐ Other _____ ☐ Refills _____
☐ Humira® (adalimumab) (PEDIATRIC) Patient weight is required for pediatric patients, _____ kg	**Starter**: ☐ 80mg/0.8mL Pre-Filled syringe Starter Package (3 syringes) ☐ 40mg /0.4mL prefilled syringes for starter dose	☐ 160mg injected day 1 --OR-- ☐ 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1 STARTER KIT -OR- QS for 1 month loading dose
	☐ 80mg/0.8mL and 40mg/0.4mL citrate-free SYRINGE starter package ☐ 40mg /0.4mL prefilled syringes for starter dose	80mg subcutaneously on day 1, then 40mg administered 2 weeks later (day 15) then maintenance dose starting on day 29.	
	Maintenance: ☐ 40mg/0.4mL citrate-free pen ☐ 40mg/0.8mL PFS ☐ 40mg/0.4mL citrate-free PFS ☐ 80mg/0.8mL citrate-free pen ☐ 40mg/0.8mL pen ☐ 20mg/0.2mL PFS	☐ Inject 40mg subcutaneously every other week ☐ Inject 20mg subcutaneousy every other week	☐ 1-month supply ☐ 3-month supply ☐ Other _____ ☐ Refills _____
☐ Stelara® (ustekinumab)	☐ 90mg/mL in each single-dose PFS	**Maintenance**: ☐ Inject 90mg subcutaneously every 8 weeks.	☐ 2-month supply ☐ Other _____ ☐ Refills _____
		Maintenance Dose Only Needed. If loading dose is needed, please see IV referral form. By selecting Stelara on this form, I am indicating that patient has already received/does not need IV loading dose at this time.	
☐ 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.

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