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

Remicade® (infliximab)
Inflectra® (infliximab-dyyb)
Renflexis® (infliximab-abda)
Avsola® (infliximab-axxq)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's 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's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/clinic/institution name _____ Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

3 Clinical Information

Primary ICD-10 code: _____ 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

INFUSION LOCATION: ☐ Patient's home ☐ Healthcare facility

Healthcare facility _____

Address _____ Phone _____

Medication	Directions	Quantity/Refills
☐ Remicade® (infliximab) ☐ Inflectra® (infliximab-dyyb) ☐ Renflexis® (infliximab-abda) ☐ Avsola® (infliximab-axxq)	**Loading dose:** ☐ 5mg/kg _____mg IV at week: 0, 2, 6 ☐ 3mg/kg _____mg IV at week: 0, 2, 6 ☐ Other _____ ☐ **Maintenance dose:** (_____mg/kg) _____mg IV every _____weeks	Dispense: ☐ 3-month supply ☐ Other _____ Refills _____

Additional required medication and supplies for home infusion (will be sent for home infusion only unless otherwise requested)

Premedication orders

☐ Acetaminophen 650mg PO 30 min prior to infusion; ☐ Diphenhydramine 50mg PO 30 min prior to infusion

☐ Other _____

Send quantity sufficient for medication days supply

Infusion method: ☐ Infusion pump (If infusion pump checked, one will be provided) ☐ Gravity

Fluids for administration and reconstitution (please strike through if not required)

Fluid options should be as follows: NS 0.9% 250mL if dose 1000mg or less, NS 0.9% 500mL if dose > 1000mg

Sterile Water as needed for reconstitution

NS 0.9% Flush (if central venous access, sterile flush will be provided)

Choose administration access: ☐ Peripheral access ☐ Central venous access

If central venous access: ☐ Flush with 10mL Sterile NS 0.9% before and after infusion. ☐ Follow with heparin 100units/mL 5mL final flush

If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed

Hypersensitivity/anaphylaxis orders

Stop infusion

Medicate with:

Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis (for children less than 30kg: Epinephrine 0.15mg)

☐ Start NS 0.9% at TKO ☐ Diphenhydramine 50mg slow IVP PRN anaphylaxis ☐ Hydrocortisone 100mg slow IVP PRN anaphylaxis

☐ Solu-Medrol 125mg slow IVP PRN anaphylaxis ☐ Diphenhydramine 50mg PO PRN Anaphylaxis

☐ Other _____

☐ Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.
*If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

☐ Lab orders _____

Prescription to include all necessary ancillary supplies (needles, syringes, etc.) If shipped to physician's office, physician accepts on behalf of patient for administration in office.

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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