

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](http://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)	<b>Loading dose:</b> 5mg/kg _____mg IV at week: 0, 2, 6 3mg/kg _____mg IV at week: 0, 2, 6 Other _____ <b>Maintenance dose:</b> ( _____ mg/kg) _____mg IV every _____ weeks	Dispense: 3-month supply Other _____ Refills _____
<b>Additional required medication and supplies for home infusion (will be sent for home infusion only unless otherwise requested)</b>		
<b>Premedication orders</b> Acetaminophen 650mg PO 30 min prior to infusion;    Diphenhydramine 50mg PO 30 min prior to infusion Other _____		Send quantity sufficient for medication days supply
<b>Infusion method:</b> Infusion pump (If infusion pump checked, one will be provided)    Gravity		
<b>Fluids for administration and reconstitution (please strike through if not required)</b> 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		
<b>Hypersensitivity/anaphylaxis orders</b> Stop infusion <b>Medicate with:</b> 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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