Prescription & Enrollment Form

HIV metabolic support

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name _____

Last name _____ Middle initial ____

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

Street address _____ Apt # _____

City _____ State ____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____

Work phone _____

Cell phone _____

Evening phone _____

E-mail address _____

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

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____

Phone _____

Insured's name _____

Insured's employer _____

Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____ Group # _____

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

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 contact and title _____

Office contact e-mail _____

Office/clinic/institution name _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State ____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic

Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: B20 Human immunodeficiency virus [HIV] disease

❑ R64 Cachexia (Serostim® only) ❑ E88.1 Lipodystrophy (Egrifta® only)

Weight (kg) _____ Height (cm) _____ Date measured _____

BMI (kg/m²) _____ Blood fasting glucose (mg/dL) _____

Waist circumference (cm) _____ Hip circumference (cm) _____

Waist-to-hip ratio (waist-to-hip ratio = waist circumference ÷ hip circumference) _____

Injection training needed: ❑ Yes ❑ No By: ❑ MD office ❑ Other _____

If prior HgH use, date started _____

❑ NKDA ❑ Known drug allergies _____

Concurrent meds _____

Please attach the following information for growth disorder diagnosis:
Drug profile, labs, growth chart where applicable

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Egrifta® (tesamorelin)	1 mg vials and administration kit	❑ Inject 2 mg under the skin once daily ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
Egfrifta ancillary supplies: ❑ Prescriber please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy		As needed for administration	Send quantity sufficient for medication days supply
❑ Serostim® (somatropin)	❑ 4 mg multi-dose vial (MDV) with bacteriostatic water for injection ❑ 5 mg single dose vial (SDV) with sterile water for injection ❑ 6 mg SDV with sterile water for injection ❑ Alternate 4 mg vial diluent: sterile water for injection (to use 4 mg vial as single use)	Inject _____ mg under the skin once daily at bedtime	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
Serostim ancillary supplies: Needle and Syringe: 3 cc syringe, with 20G, 1" needles for reconstitution And one of the following for injection: ❑ 27G, 1/2" needles ❑ 29G, 1/2" needles ❑ 30G, 1/2" needles			Send quantity sufficient for medication days supply
❑ Other _____			

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

I certify that this medication is not being prescribed for anti-aging, cosmetic or athletic performance. I further certify human growth hormone is being prescribed for the medical condition noted above and is medically necessary.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____

Date Substitution allowed Date Dispense as written

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.

Please fax completed form to your endo 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.