

Prescription & Enrollment Form  
**Rheumatoid arthritis—oral**



**Four simple steps to submit your referral.**

**1 PATIENT INFORMATION**

New patient  Current

Patient's name \_\_\_\_\_  
 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 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 name and title \_\_\_\_\_  
 If NP or PA, under direction of Dr. \_\_\_\_\_  
 Office contact and title \_\_\_\_\_  
 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: \_\_\_\_\_  
 Pertinent medical history and clinical course \_\_\_\_\_  
 \_\_\_\_\_  
 Patient wt \_\_\_\_\_ kg Date wt obtained \_\_\_\_\_  
 NKDA  Known drug allergies \_\_\_\_\_  
 \_\_\_\_\_  
 Concurrent meds \_\_\_\_\_  
 \_\_\_\_\_

**4 PRESCRIBING INFORMATION**

Medication	Strength / Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Olumiant® (baricitinib)	<input type="checkbox"/> 2 mg tablets	<input type="checkbox"/> Take 2 mg by mouth once daily <input type="checkbox"/> Other _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Xeljanz® (tofacitinib citrate)	<input type="checkbox"/> 5 mg tablets	<input type="checkbox"/> Take 5 mg by mouth twice daily <input type="checkbox"/> Take 5 mg by mouth once daily <input type="checkbox"/> Other _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Xeljanz XR® (tofacitinib citrate)	<input type="checkbox"/> 11 mg tablets	<input type="checkbox"/> Take 11 mg by mouth once daily <input type="checkbox"/> Other _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Other _____			<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____

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

**PHYSICIAN SIGNATURE REQUIRED**

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.

**Please fax completed form to the RA team at 888.302.1028.**  
 To reach your team, call toll-free 888.608.9010.  
**You can now track shipments for all your Accredo patients.**  
 Go to <https://prescribers.accredo.com> and click "Help" to register.

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