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

Rheumatoid Arthritis – Injectable

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 _____

Sex at birth: ☐ 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 ☐ Influsion site If infusion site, complete information below dotted line:

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 pegol)	**Loading dose:** ☐ 200mg/mL solution in a single-dose Prefilled Syringe 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 No refills
	Maintenance dose: ☐ 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 ☐ Inject 200mg subcutaneously every 2 weeks ☐ Other _____	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Cosentyx® (secukinumab)	**Loading dose:** ☐ 75mg Syringe	☐ Inject _____ mg subcutaneously at weeks 0, 1, 2, 3 and 4 followed by _____ every 4 weeks	QS for 5 doses No refills
	Maintenance dose: ☐ 150mg Prefilled Pen ☐ 150mg PFS ☐ 300mg (2-150mg injections) Prefilled Pen ☐ 300mg (2-150mg injections) PFS	☐ Inject _____ mg subcutaneously every 4 weeks ☐ Other _____	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Enbrel® (etanercept)	☐ 25mg Single Use vial ☐ 25mg PFS ☐ 50mg PFS ☐ 50mg SureClick™ ☐ 50mg Mini Cartridge	☐ Inject 50mg subcutaneously once a week ☐ Other _____	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Humira® (adalimumab)	☐ 10mg/0.1mL prefilled syringe ☐ 20mg/0.2mL prefilled syringe ☐ 40mg/0.4mL (citrate free) ☐ 40mg/0.8mL ☐ 80mg/0.8mL pen (citrate free) ☐ Prefilled Pen ☐ PFS	☐ Inject 10mg subcutaneously every other week ☐ Inject 20mg subcutaneously every other week ☐ Inject 40mg subcutaneously every other week ☐ Inject 80mg subcutaneously every other week ☐ Other _____	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Kevzara® (sarilumab)	☐ 150mg/1.14mL Prefilled Pen ☐ 150mg/1.14mL PFS ☐ 200mg/1.14mL Prefilled Pen ☐ 200mg/1.14mL PFS	☐ Inject 150mg subcutaneously every 2 weeks ☐ Inject 200mg subcutaneously every 2 weeks	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Other _____			
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			Send quantity sufficient for medication days supply

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.