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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 Preferred pronouns _____ Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email 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 _____

Office/clinic/institution name _____

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 email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: Patient's home Prescriber's office Infusion 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 site contact _____ Phone _____ Fax _____ Email _____

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	Strength/Formulation	Directions	Quantity/Refills
Amjevita (adalimumab- atto) Citrate Free	20mg/0.4mL prefilled syringe	Inject 20mg subcutaneously every other week	1-month supply 3-month supply Other _____ Refills _____
	40mg/0.8mL SureClick AutoInjector 40mg/0.8mL Prefilled Syringe	Inject 40mg subcutaneously every other week Inject 80mg subcutaneously every other week Other _____	
Cimzia® (certolizumab pegol)	200mg/mL solution in a single-dose prefilled syringe (PFS) 200mg/mL lyophilized powder in a single-dose vial for reconstitution	Loading dose: Inject 400mg subcutaneously at weeks 0, 2 and 4	1 STARTER KIT No refills
		Maintenance dose: Inject 400mg subcutaneously every 4 weeks Inject 200mg subcutaneously every 2 weeks Other _____	1-month supply 3-month supply Other _____ Refills _____
Cosentyx® (secukinumab)	75mg Syringe	Loading dose: Inject _____mg subcutaneously at weeks 0, 1, 2, 3 and 4 followed by _____ every 4 weeks	QS for 5 doses No refills
	150mg Prefilled Pen 150mg PFS 300mg (2-150mg injections) Prefilled Pen 300mg (2-150mg injections) PFS	Maintenance dose: 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	Inject 50mg subcutaneously once a week Other _____	1-month supply 3-month supply Other _____ Refills _____
	50mg SureClick™ 50mg Mini Cartridge		
Humira® (adalimumab)	10mg/0.1mL prefilled syringe 20mg/0.2mL prefilled syringe	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 _____
	40mg/0.4mL (citrate free) 40mg/0.8mL 80mg/0.8mL pen (citrate free)		
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 _____

If NP or PA, under direction of Dr. _____ Statute License No: _____

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.

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Ilaris® (canakinumab) Patient's weight (kg): _____	Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) 4 years and older and weight 15kg to 40kg (2mg/kg): _____mg 4 years and older and weight more than 40kg: 150mg	Subcutaneously every 8 weeks	1-month supply 3-month supply Other _____ Refills _____
	Still's Disease (4mg/kg) _____mg	Subcutaneously every 4 weeks	
	Systemic Juvenile Idiopathic Arthritis (SJIA) 2 years and older and weight greater than or equal to 7.5kg (4mg/kg/dose): _____mg	Subcutaneously every 4 weeks	
	Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency (HIDS/MKD), and Familial Mediterranean Fever (FMF) 2 years and older and weight less than or equal to 40kg (2mg/kg up to 4mg/kg): _____mg 2 years and older and weight more than 40kg: 150mg	Subcutaneously every 4 weeks	
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

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