

Please fax all 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](https://myaccredopatients.com) to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

**Rinvoq® (upadacitinib)**

**EVERNORTH**  
HEALTH SERVICES

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 \_\_\_\_\_

Preferred patient first name \_\_\_\_\_ Preferred patient last name \_\_\_\_\_

Sex at birth: Male Female Gender identity \_\_\_\_\_ 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 \_\_\_\_\_

**Provider will read the following statement to patient:** By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

## 2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_

Office/clinic/institution name \_\_\_\_\_

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 \_\_\_\_\_

Deliver product to: Prescriber's office Patient's home

## 3 Clinical Information

**Primary ICD-10 code (REQUIRED):** \_\_\_\_\_

NKDA Known drug allergies \_\_\_\_\_

Concurrent meds \_\_\_\_\_

Patient weight \_\_\_\_\_ Date weight taken \_\_\_\_\_

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_ Date of birth \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_ Phone \_\_\_\_\_

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Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Rinvoq® (upadacitinib) Atopic dermatitis	15mg	Take 1 tablet (15mg) by mouth once daily	1-month supply 3-month supply Other _____ Refills _____
	30mg	Take 1 tablet (30mg) by mouth once daily (inadequate response to 15mg dose)	1-month supply 3-month supply Other _____ Refills _____
Rinvoq® (upadacitinib) Psoriatic Arthritis Rheumatoid Arthritis Ankylosing Spondylitis	15mg	Take 1 tablet by mouth once daily	1-month supply 3-month supply Other _____ Refills _____
Rinvoq® (upadacitinib) Rheumatoid Arthritis	15mg	Take 1 tablet by mouth once daily	1-month supply 3-month supply Other _____ Refills _____
Rinvoq® (upadacitinib) Ulcerative Colitis	Loading Dose 45mg	Take 1 tablet (45mg) by mouth once daily for 8 weeks	1-month supply (28 ct bottle) 1 refill
	Maintenance Dose 15mg 30mg	Take 1 tablet (15mg) by mouth once daily Take 1 tablet (30mg) by mouth once daily (for patients with refractory, severe, or extensive disease)	1-month supply 3-month supply Other _____ Refills _____
Other			

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.