Please fax both pages of completed form to your team at 888.686.1035.

To reach your team, call toll-free 877.554.3089.

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

Sickle Cell Disease (SCD)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

New patient   Current patient

Patient's first name ______ Last name ______ Middle initial ______

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 ______

Insurance company ______ Phone ______

Insured's name ______ Insured's employer ______

Relationship to patient ______ Identification # ______ Policy/group # ______

Prescription card: Yes   No   If yes, carrier ______ Policy # ______ Group # ______

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 ______ Prescriber's first name ______ Last name ______

Prescriber's title ______ If NP or PA, under direction of Dr. ______

Phone ______ Fax ______ NPI # ______ License # ______

Office contact and title ______

Office contact phone number ______ Office contact e-mail ______

Street address ______ Suite # ______

City ______ State ______ Zip ______

3 Clinical Information

Sickle Cell Diagnosis: D57 (sickle cell disorders)   D57.0 (Hb-SS disease with crisis)   D57.1 (SCD without crisis)
D57.2 (Sickle-cell/Hb-C disease)   D57.00 (Hb-SS disease with crisis, unspecified)
D57.40 (Sickle-cell thalassemia without crisis)   D57.20 (Sickle-cell/Hb-C disease without crisis)
D57.219 (Sickle-cell/Hb-C disease with crisis, unspecified)   Other

Height ______ cm/in   Weight ______ kg/lbs   Date taken ______

NKDA   Known drug allergies ______

Concurrent meds ______

Additional clinical information ______

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
Endari®	5 Gram (GM) Packet	(see dosing table below) Mix 1 packet (5 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4-6 ounces of food and take by mouth 2 times daily. Mix 2 packet(s) (10 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4-6 ounces of food and take by mouth 2 times daily. Mix 3 packet(s) (15 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4-6 ounces of food and take by mouth 2 times daily. Other ________	Dispense: 1-month supply 3-month supply Other ________ Number refills authorized ________
Oxbryta®	500mg Tablets for oral use	Take 3 tablets (1500mg) by mouth once daily Other ________	Dispense: 1-month supply 3-month supply Other ________ Number refills authorized ________
Oxbryta®	300mg Tablets for oral suspension	(see dosing table below) Take 5 tablets (1500mg) dispersed for oral suspension in 25mL of clear drink daily. Take 3 tablets (900mg) dispersed for oral suspension in 15mL of clear drink daily. Take 2 tablets (600mg) dispersed for oral suspension in 10mL of clear drink daily. Other ________ Dispense tablets for oral suspension immediately before administration in a cup and in room temperature clear liquid (such as drinking water or clear soda) before swallowing. Minimum recommended volume of clear drink is 5mL (1 teaspoon) per tablet for oral suspension.	Dispense: 1-month supply 3-month supply Other ________ Number refills authorized ________

Endari® dosing:

Weight in kilograms	Per dose in grams	Per day in grams	Packets per dose	Packets per day
less than 30	5	10	1	2
30 to 65	10	20	2	4
greater than 65	15	30	3	6

Oxbryta® 300mg dosing:

Weight in kilograms	Recommended dose (once daily)
40kg or greater	1,500mg
20kg to less than 40kg	900mg
10kg to less than 20kg	600mg

Prescriber's signature required (sign below) (Prescriber 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.

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