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
Ulcerative Colitis

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 _____

☐ 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:

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
☐ Humira® (adalimumab) (ADULT)	**Starter:** ☐ 80mg/0.8mL Pre-Filled Pen Starter Package (3 PENS) ☐ 40mg/0.8mL pens starter kit ☐ 40mg /0.4mL prefilled syringes for starter dose	☐ 160mg injected day 1 ☐ 80mg injected each day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) followed by maintenance dose starting on day 29	1 STARTER KIT -OR- QS for 1 month loading dose
	Maintenance: ☐ 40mg/0.4mL citrate-free pen ☐ 40mg/0.4mL citrate-free prefilled syringe (PFS) ☐ 40mg/0.8mL pen ☐ 40mg/0.8mL PFS	☐ Inject 40mg subcutaneously every other week.	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Humira® (adalimumab) (PEDIATRIC)	**Starter:** ☐ 80mg/0.8mL Pre-Filled Pen UC Starter Package (4 PENS) ☐ 40mg /0.4mL prefilled syringes for starter dose	☐ 160mg injected day 1 --OR-- ☐ 80mg injected each day 1 and day 2 then 80mg administered weekly for 2 weeks (a dose on day 8 and day 15) then maintenance dose starting on day 29.	1 STARTER KIT -OR- QS for 1 month loading dose
	☐ 40mg /0.4mL prefilled syringes for starter dose	80mg subcutaneously on day 1, then 40mg administered weekly for 2 weeks (a dose on day 8 and day 15) then maintenance dose starting on day 29.	
	Maintenance: ☐ 40mg/0.4mL citrate-free pen ☐ 40mg/0.4mL citrate-free PFS ☐ 40mg/0.8mL pen ☐ 40mg/0.8mL PFS ☐ 80mg/0.8mL citrate-free pen ☐ 20mg/0.2mL PFS	☐ Inject 80mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week ☐ Inject 40mg subcutaneously every other week ☐ Inject 20mg subcutaneously every week	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Simponi® (golimumab)	☐ 100mg/mL in each single-dose PFS	**Loading dose:** ☐ Inject 200mg subcutaneously at week 0, followed by 100mg subcutaneously at week 2	3 doses for loading/ induction
	☐ 100mg/mL in each single-dose pen	**Maintenance dose:** ☐ Inject 100mg subcutaneously every 4 weeks.	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Stelara® (ustekinumab)	☐ 90mg/mL in each single-dose PFS	**Maintenance dose:** ☐ Inject 90mg subcutaneously every 8 weeks.	☐ 2-month supply ☐ Other _____ Refills _____
		Maintenance Dose Only Needed. If loading dose is needed, please see IV referral form. By selecting Stelara on this form, I am indicating that patient has already received/does not need IV loading dose at this time.	
☐ Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

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.

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
☐ Xeljanz IR	☐ 5mg tablets ☐ 10mg tablets	**Loading dose:** ☐ Take 10mg by mouth twice daily for 8 weeks, followed by 5mg twice daily	QS for 2 month loading dose
		Maintenance dose: ☐ Take 10mg by mouth twice daily ☐ Take 5mg by mouth twice daily ☐ Take 5mg by mouth once daily	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Xeljanz ER®	☐ 11mg ER tablets ☐ 22mg ER tablets	**Loading dose:** 22mg once daily for at least 8 weeks, followed by 11mg once daily	QS for 2 month loading dose
		Maintenance dose: Take 11mg by mouth once daily	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Zeposia® (ozanimod)	**Starter:** ☐ Starter Pack (28 day) ☐ Starter Pack (7 day)	Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule for 3 days, then one 0.92mg capsule daily thereafter	1 KIT
	Maintenance dose: ☐ 0.92mg capsules	Take one capsule daily	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

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.

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