Please fax all pages of completed form to your team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
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 – Humira and Biosimilars

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

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: 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 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
☐ adalimumab-aacf Citrate Free **(ADULT)**	☐ 40mg/0.8mL PEN	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Amjevita™ (adalimumab-atto) Citrate Free **(ADULT)**	☐ 40mg/0.4mL SureClick Autoinjector ☐ 40mg/0.4mL prefilled syringe (PFS) ☐ 80mg/0.8mL SureClick Autoinjector	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Cyltezo® (adalimumab-adbm) Citrate Free **(ADULT)**	☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ adalimumab-adbm Citrate Free **(ADULT)**	☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ 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	Strength/Formulation	Directions	Quantity/Refills
☐ Hadlima™ (adalimumab-bwwd) Citrate Free **(ADULT)**	☐ 40mg/0.8mL PFS ☐ 40mg/0.4mL PFS ☐ 40mg/0.8mL PushTouch Autoinjector ☐ 40mg/0.4mL PushTouch Autoinjector	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Humira® (adalimumab) **(ADULT)**	☐ 80mg/0.8mL prefilled PEN Starter Package (3 PENS) ☐ 40mg/0.8mL PENS starter kit ☐ 40mg/0.4mL PFS for starter dose	**Loading dose:** ☐ 160mg injected day 1 --OR-- ☐ 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 No Refills
	☐ 40mg/0.4mL citrate free PEN ☐ 40mg/0.4mL citrate free PFS ☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	**Maintenance dose:** ☐ Inject 40mg subcutaneously every other week.	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Humira® (adalimumab) **(PEDIATRIC)**	☐ 80mg/0.8mL prefilled PEN UC Starter Package (4 PENS) ☐ 40mg/0.4mL PFS for starter dose	**Loading 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 No Refills
	☐ 40mg/0.4mL PFS 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.	
	☐ 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	**Maintenance dose:** ☐ 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 Refill QS 1 year unless otherwise noted ☐ Other _____
☐ 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	Strength/Formulation	Directions	Quantity/Refills
☐ Hyrimoz® (adalimumab-adaz) Citrate Free **(ADULT)**	☐ 80mg/0.8mL PEN Starter Pack (3 PENS)	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
	☐ 40mg/0.4mL PEN ☐ 40mg/0.4mL PFS	**Maintenance dose:** ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ adalimumab-adaz Citrate Free **(ADULT)**	☐ 80mg/0.8mL PEN	**Loading dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
	☐ 40mg/0.4mL PEN ☐ 40mg/0.4mL PFS	**Maintenance dose:** ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Simlandi® (adalimumab-ryvk) Citrate Free	☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL PEN	**Loading Dose:** ☐ Inject 160mg on day 1 --OR-- ☐ Inject 80mg on day 1 and day 2 followed by 80mg subcutaneously 2 weeks later (day 15) then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
		Maintenance Dose: ☐ Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ 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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