

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](http://MyAccredoPatients.com) to log in or get started.

Prescription & Enrollment Form

# Ulcerative Colitis – Humira and Biosimilars

**accredo**<sup>®</sup>  
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 \_\_\_\_\_

## 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 <b>(ADULT)</b>	40mg/0.8mL pen	<b>Loading dose:</b> 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
		<b>Maintenance dose:</b> Inject 40mg subcutaneously every other week	1-month supply 3-month supply Other _____ Refills _____
Amjevita™ (adalimumab-atto) Citrate Free <b>(ADULT)</b>	40mg/0.8mL SureClick Autoinjector 40mg/0.8mL prefilled syringe (PFS) 40mg/0.4mL SureClick Autoinjector 40mg/0.4mL PFS 80mg/0.8mL SureClick Autoinjector	<b>Loading dose:</b> 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
		<b>Maintenance dose:</b> 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 <b>(ADULT)</b>	40mg/0.8mL pen 40mg/0.8mL PFS	<b>Loading dose:</b> 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
		<b>Maintenance dose:</b> Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
adalimumab-adbm Citrate Free <b>(ADULT)</b>	40mg/0.8mL pen 40mg/0.8mL PFS	<b>Loading dose:</b> 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
		<b>Maintenance dose:</b> 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 <b>(ADULT)</b>	40mg/0.8mL PFS 40mg/0.4mL PFS 40mg/0.8mL PushTouch Autoinjector	<b>Loading dose:</b> 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 PushTouch Autoinjector	<b>Maintenance dose:</b> Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Humira® (adalimumab) <b>(ADULT)</b>	80mg/0.8mL prefilled pen Starter Package (3 pens) 40mg/0.8mL pens starter kit 40mg/0.4mL PFS for starter dose	<b>Loading dose:</b> 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	<b>Maintenance dose:</b> Inject 40mg subcutaneously every other week.	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Humira® (adalimumab) <b>(PEDIATRIC)</b>	80mg/0.8mL prefilled pen UC Starter Package (4 pens) 40mg/0.4mL PFS for starter dose	<b>Loading dose:</b> 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	<b>Maintenance dose:</b> 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 <b>(ADULT)</b>	80mg/0.8mL Pen Starter Pack (3 pens)	<b>Loading dose:</b> 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	<b>Maintenance dose:</b> Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
adalimumab-adaz Citrate Free <b>(ADULT)</b>	40mg/0.4mL pen 40mg/0.4mL PFS	<b>Loading dose:</b> 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
		<b>Maintenance dose:</b> Inject 40mg subcutaneously every other week	1-month supply 3-month supply Refill QS 1 year unless otherwise noted Other _____
Idacio® (adalimumab-aacf) Citrate Free <b>(ADULT)</b>	40mg/0.8mL PFS 40mg/0.8mL Pen	<b>Loading dose:</b> 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
		<b>Maintenance dose:</b> 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 pen	<b>Loading Dose:</b> 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
		<b>Maintenance Dose:</b> 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.



The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. All rights in the product names, trade names or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners. © 2024 Accredo Health Group, Inc. | An Express Scripts Company. All rights reserved. ULC-00002-H-111124 CRP1357109