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 to log in or get started.

Prescription & Enrollment Form

Rheumatoid Arthritis – Humira and Biosimilars

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 _____

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 weight _____ Date weight 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 Patient weight is requested for pediatric patients: _____ kg	☐ 40mg/0.8mL PEN	**For Children 2 yrs and older weighing 30kg (66 lbs) and greater:** ☐ Inject 40mg subcutaneously every other week **Adults** ☐ Inject 40mg subcutaneously every other week ☐ Inject 80mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week ☐ Other _____	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Amjevita™ (adalimumab-atto) Citrate Free Patient weight is requested for pediatric patients: _____ kg	☐ 10mg/0.2mL prefilled syringe (PFS) ☐ 20mg/0.2mL PFS ☐ 40mg/0.4mL SureClick Autoinjector ☐ 40mg/0.4mL PFS ☐ 80mg/0.8mL SureClick Autoinjector	☐ Inject 10mg subcutaneously every other week ☐ Inject 20mg subcutaneously every other week ☐ Inject 40mg subcutaneously every other week ☐ Inject 80mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Cyltezo® (adalimumab-adbm) Citrate Free Patient weight is requested for pediatric patients: _____ kg	☐ 10mg/0.2mL PFS ☐ 20mg/0.4mL PFS ☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	☐ Inject 10mg subcutaneously every other week ☐ Inject 20mg subcutaneously every other week ☐ Inject 40mg subcutaneously every other week ☐ Inject 80mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ adalimumab-adbm Citrate Free Patient weight is requested for pediatric patients: _____ kg	☐ 10mg/0.2mL PFS ☐ 20mg/0.4mL PFS ☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	☐ Inject 10mg subcutaneously every other week ☐ Inject 20mg subcutaneously every other week ☐ Inject 40mg subcutaneously every other week ☐ Inject 80mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Hadlima™ (adalimumab-bwwd) Citrate Free	☐ 40mg/0.8mL PFS ☐ 40mg/0.4mL PFS ☐ 40mg/0.8mL PushTouch Autoinjector ☐ 40mg/0.4mL PushTouch Autoinjector	☐ Inject 40mg subcutaneously every other week ☐ Inject 80mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other			
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			Send quantity sufficient for medication days supply

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
☐ Humira® (adalimumab) Patient weight is requested for pediatric patients: _____ kg	☐ 10mg/0.1mL PFS ☐ 20mg/0.2mL PFS ☐ 40mg/0.4mL PFS (citrate free) ☐ 40mg/0.4mL PEN (citrate free) ☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL PEN ☐ 80mg/0.8mL PEN (citrate free)	☐ Inject 10mg subcutaneously every other week ☐ Inject 20mg subcutaneously every other week ☐ Inject 40mg subcutaneously every other week ☐ Inject 80mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Hyrimoz® (adalimumab-adaz) Citrate Free Patient weight is requested for pediatric patients: _____ kg	☐ 10mg/0.1mL PFS ☐ 20mg/0.2mL PFS ☐ 40mg/0.4mL PEN ☐ 40mg/0.4mL PFS ☐ 80mg/0.8mL PEN	☐ Inject 10mg subcutaneously every other week ☐ Inject 20mg subcutaneously every other week ☐ Inject 40mg subcutaneously every other week ☐ Inject 80mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ adalimumab-adaz Citrate Free	☐ 40mg/0.4mL PEN ☐ 40mg/0.4mL PFS ☐ 80mg/0.8mL PEN	☐ Inject 40mg subcutaneously every other week ☐ Inject 80mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Simlandi® (adalimumab-ryvk) Citrate Free Patient weight is requested for pediatric patients: _____ kg	☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL PEN	**For Children 2 yrs and older weighing 30kg (66lbs) and greater:** ☐ Inject 40mg subcutaneously every other week **Adults** ☐ Inject 40mg subcutaneously every other week ☐ Inject 80mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week ☐ Other _____	☐ 1-month supply ☐ 3-month supply Refill QS 1 year unless otherwise noted ☐ Other _____
☐ Other			
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			Send quantity sufficient for medication days supply

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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