### 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 <u>MyAccredoPatients.com</u> to log in or get started.

#### **Prescription & Enrollment Form** Rheumatoid Arthritis – Humira and Biosimilars Ala Moana Blvd., Suite 404 Ionolulu, HI 96813 Four simple steps to submit your referral. Please provide copies of front and back of all medical T **Patient Information** and prescription insurance cards. New patient Current patient Last name \_\_\_\_\_ Middle initial \_\_\_\_ Patient's first name Preferred patient first name \_\_\_\_\_ Preferred patient last name Female Gender identity \_\_\_\_\_ Pronouns \_\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_ Sex at birth: Male \_\_\_\_ Apt # \_\_\_\_\_ Date of birth \_\_\_\_\_ Street address \_\_\_\_\_ \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_ Parent/guardian (if applicable) \_\_\_\_\_ \_\_\_\_\_ Cell phone \_\_\_\_\_\_ Email address \_\_\_\_\_ Home phone \_\_\_\_\_ Alternate caregiver/contact \_\_\_\_\_ \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_ Home phone \_\_\_\_ 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 ne	eded	
Office/clinic/institu	ition name					
Prescriber info: Prescriber's first name				Las	name	
Prescriber's title _			If NP	or PA, under direc	tion of Dr	
Office phone		Fax		NPI #	License :	#
Office contact and	title			Office	e contact email	
Office street addre	SS					Suite #
City			State			_ Zip
Infusion location:	Patient's home	Prescriber's office	Infusion site	If infusion site, co	mplete information below	v dotted line:
Infusion info: Infus	sion site name			Clinic/hospital	affiliation	
Site street address	i				Si	uite #
City			State			_ Zip
Infusion site contac	t	Phon	e	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	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 <sup>™</sup> (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: (Prescr Dispense ancillary supplie the therapy as needed.	iber to strike through if not required) s such as needles, syringes, sterile water,	etc. and home medical equipment necessary to administer	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	
JIGH	
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 <sup>®</sup> (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 <sup>®</sup> (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: (Pr Dispense ancillary sup to administer the thera	L rescriber to strike through if not required plies such as needles, syringes, sterile w apy as needed.	l ) /ater, etc. and home medical equipment necessary	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

D

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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