APOKYN® apomorphine hydrochloride injection

VA Prescription & Enrollment Form

PLEASE PRINT

Phone: (888) 454-8860 Fax: (888) 454-8488

accredo®

STEP 1: Complete Physician Information

Ship to: ☐ Patient or ☐ VA Pharmacy Date shipment needed: _____

Physician Information:

VA Facility:

VA Address:

City/County: State ZIP:

Physician Name:

Phone: Fax:

State License # Nat'l Provider ID:

☐ *VA Patient Release of Information signed*

STEP 2: Check Boxes for: Start-up Rx and Titration Orders *(Check all boxes that apply.)*

PRESCRIPTION ONLY VALID IF RECEIVED BY FACSIMILE.

Prescription

Attention New York Prescribers: Please submit prescription on an original New York prescription blank.

Rx: APOKYN® 3 mL Cartridges—Administer doses as directed

☐ Initial prescription = one titration kit includes:

- One box of five 3 mL cartridges. Sig: Under medical supervision, initially inject 0.2 mL
- Titrate by 0.1 mL as directed by physician at initiation, every few days, and as needed per patient response until patient reaches maximum tolerated dose or to a max dose of 0.6 mL per "*off* episode"
- One APOKYN Pen Pack (includes one pen device and six pen needles). Sig: Under medical supervision, use to administer APOKYN. 1 day supply.
- One box of 100 BD Ultra-Fine™ pen needles 29 g x ½ in. Sig: Use with APOKYN pen device to administer APOKYN.
- One 1.5 quart Sharps Container. Sig: Use to dispose of pen needles.

Rx: Trimethobenzamide HCl 300 mg Capsules

☐ Take one capsule by mouth three times daily for nausea. Begin taking three days prior to initial APOKYN dose. Quantity: 42

OR

Ongoing Rx *(Check all boxes that apply.)*

☐ **APOKYN 3 mL Cartridges**

Sig: Inject _____ mL/dose _____ times per day as directed.

Days supply: ☐ 30 day ☐ 90 day ☐ Other:____ Refills: _____

Do not exceed _____doses per day

Titrate by 0.1 mL as directed by physician at initiation, every few days, and as needed per patient response until patient reaches maximum tolerated dose or to a max dose of 0.6 mL per "*off* episode"

☐ **BD Ultra-Fine™ pen needles 29 g x ½ in**

Quantity: Box of 100. Sig: Under medical supervision, use to administer APOKYN.

Days supply: ☐ 30 day ☐ 90 day ☐ Other:____ Refills: _____

☐ **Trimethobenzamide HCl 300 mg capsules**

Take one capsule by mouth three times daily for nausea. Begin taking three days prior to initial APOKYN dose. Quantity: 90 Refills: _____

Sign Statement of Medical Necessity

SIGNATURE REQUIRED FOR START-UP Rx OR ONGOING Rx.

I certify APOKYN Therapy is necessary for this patient. I authorize the VA to act on my behalf for the purpose of transmitting this prescription to Accredo for processing and dispensing.

Instructions: Please select the line for *dispense as written* or *substitution permitted*.

Prescriber's Signature:

(Signature required. No stamps please. Dispense as Written.)

Prescriber's Signature:

(Signature required. No stamps please. Substitution Permitted.)

Date: _____

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.

STEP 3: Complete VA Pharmacy Information

Attention Prescriber: Please forward this prescription and enrollment form to the VA pharmacy below for review and fulfillment.

VA Pharmacy Information:

Pharmacy Name: Pharmacy Contact:

Phone: Fax:

Address:

City/County: State: ZIP:

Billing Address (if different):

STEP 4: Complete Patient Information

Patient Information:

Patient Name:

Date of Birth: Gender: ☐ M ☐ F

Language: ☐ English ☐ Spanish ☐ Other _____

Daytime Phone: Evening Phone:

Alternate Contact: Phone Number:

OK to leave message with Alternate Contact? ☐ Yes ☐ No

Address **(No P.O. Box):**

City/County: State: ZIP:

STEP 5: List Clinical Diagnosis and Related Information

Clinical Information:

Diagnosis: _____ ICD10

☐ No Known Drug Allergies

Please list all Drug and Non-Drug allergies: _____

Please list all other medications that the patient is currently taking:

Office Contact: _____

Notes: _____

STEP 6: Attention Dispensing Pharmacy

A delivery confirmation to the VA Pharmacy identified in Step 3 must be sent within 72 hours for any prescription sent directly to a patient.

Use the VA Delivery Confirmation Form on the reverse side of this sheet.

If in-home initiation support and education by the US WorldMeds Circle of Care Nurse Educator is requested by the patient, a copy of the SMN must be faxed to 1-888-525-2431.

PLEASE FAX COMPLETED FORM TO THE APOKYN PHARMACY PROVIDER AT THE TOP OF THE PAGE.

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To Be Completed by Specialty Pharmacy for Prescriptions Sent Directly to the Patient.

APOKYN® (apomorphine hydrochloride injection)
VA Delivery Confirmation

TO: _____

FROM: _____

Patient Name: _____

Drug Name: _____

NDC#: _____

Quantity: _____

Date Shipped: _____

Date Received: _____

Confirmation/
Tracking #: _____