

APOKYN® (apomorphine hydrochloride injection) Prescription Form for VA Patients

Forward completed form to the VA Pharmacy. The VA Pharmacy will fax completed form to Accredo at 1- 800-464-2107

Please complete all fields to avoid delays in processing.



Phone: 1-800-258-2231

DUNS#: 363066452

VA PATIENT INFORMATION			
First name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Address:
Middle initial and last name:		City:	State: ZIP:
DOB:		Email:	
Home phone:		Preferred language other than English:	
Cell Phone/Other:		Authorized representative:	
Preferred number: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> OK to leave message		Relationship to patient:	
Best time to reach me: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening		Phone number (authorized representative): <input type="checkbox"/> OK to leave message	
<input type="checkbox"/> Check here for delivery directly to patient's shipping address listed above. If information is incomplete, the prescription will be shipped to the VA pharmacy listed below.			
VA PHARMACY INFORMATION			
VA name:		Payment method: <input type="checkbox"/> Credit card (call pharmacy contact) <input type="checkbox"/> E-Invoice Tungsten Network	
Address:			
City:	State:	ZIP:	
Primary purchasing contact:		Purchase order #:	
Secondary purchasing contact:			
Phone:	Fax:	Phone:	Fax:
Email:		Email:	
Primary clinical contact:		Secondary clinical contact:	
Phone:	Fax:	Phone:	Fax:
Email:		Email:	
PRESCRIBER INFORMATION			
Today's date:			
Prescriber name:		Address:	
License #:	or NPI #	City:	State: ZIP:
Office contact name:		Email:	
Office contact phone:		Phone:	Fax:
DIAGNOSIS			
Diagnosis (ICD-10): <input type="checkbox"/> G20 Parkinson's disease <input type="checkbox"/> Other:			
APOKYN® (apomorphine hydrochloride injection) PRESCRIPTION INFORMATION			
Check Initiation Prescription or Maintenance Prescription			
APOKYN Initiation Prescription <input type="checkbox"/> Rx APOKYN 3 mL Cartridges – Administer doses as directed <ul style="list-style-type: none"> 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 pen needles). Sig: Under medical supervision, use to administer APOKYN One box of 100 BD Ultra-Fine™ pen needles 29 g x ½ in. Sig: Use with APOKYN pen One 1.5 quart Sharps Container. Sig: Use to dispose of pen needles 		APOKYN Maintenance Prescription <input type="checkbox"/> APOKYN 3 mL Cartridges <p>Sig: Inject _____ mL (dose) subcutaneously, _____ times (doses) per day <i>Maximum 5 times (doses)/day</i></p> <p>Days supply: <input type="checkbox"/> 30 day <input type="checkbox"/> 90 day <input type="checkbox"/> Other Refills: _____</p> <ul style="list-style-type: none"> 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 <input type="checkbox"/> BD Ultra-Fine™ pen needles 29 g x ½ in Days supply: <input type="checkbox"/> 30 day <input type="checkbox"/> 90 day <input type="checkbox"/> Other Refills: _____ - Quantity: Box of 100, use to administer APOKYN	
Clinical Information: <input type="checkbox"/> No Known Drug Allergies Please list all drug and non-drug allergies: _____ Concomitant medications: _____			
IMPORTANT: If complementary in-home initiation support and education by the Supernus® Circle of Care™ Clinical Educator is requested by the patient, a copy of this prescription form must also be faxed to the Supernus HUB at 1-888-525-2431.			
I authorize the VA Pharmacy to act on my behalf for the purpose of transmitting this prescription to Accredo for the purpose of processing and dispensing this prescribed medication for my patient.			
>> Prescriber Signature _____ (Dispense as written)		>> Prescriber Signature _____ (Substitutions permitted)	
Date (MM/DD/YYYY):		Date (MM/DD/YYYY):	
Original signature required. Signature stamp not acceptable.			

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