APOKYN®
apomorphine hydrochloride injection

accredo®
a medco company®

VA Prescription & Enrollment Form

PLEASE PRINT

Phone: (866) 898-0104 Fax: (866) 898-0069

STEP 1: Complete Physician Information

Physician Information:

VA Facility: _____

VA Address: _____

City: _____ 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

Prescription:

Rx: APOKYN® 3 mL Cartridges

Administer doses as directed

☐ Initial prescription = one titration kit (sig: use as directed) includes:

- One box of five 3 mL cartridges
- One APOKYN Pen Pack (includes one pen device and six pen needles)
- One box of 100 BD Ultra-Fine™ pen needles 29 g x ½ in
- One 1.5 quart Sharps Container

(Sig: use as directed)

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

☐ **APOKYN 3 mL Cartridges**

_____mL/dose Estimated number of doses per day: _____

Days supply: ☐ 30 ☐ Other: _____ Refills: _____

Do not exceed _____ doses per day

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

Quantity: Box of 100 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: _____

STEP 3: Complete VA Pharmacy Information

VA Pharmacy Information:

Pharmacy Contact: _____

Phone: _____

Procurement Contact: _____

Phone: _____

STEP 4: Complete Patient Information

Patient Information:

Patient Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Language: ☐ English ☐ Spanish ☐ Other _____

Daytime Phone: _____ Evening Phone: _____

Alternate Contact: _____ Phone Number: _____

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

City: _____ State: _____ Zip: _____

STEP 5: Sign Statement of Medical Necessity

Statement of Medical Necessity:

I certify APOKYN therapy is necessary for this patient.

Office Contact: _____

Prescriber's Signature: _____

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

Date: _____

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