

# PRESCRIPTION & ENROLLMENT FORM

New Patient  
 Current

## 1 PATIENT INFORMATION

Patient's Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  Male  Female Last 4 digits of SSN \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Parent/Guardian (if applicable) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_  
Phone No. \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Identification No. \_\_\_\_\_ Policy/Group No. \_\_\_\_\_  
Prescription Card  No  Yes If Yes, Carrier \_\_\_\_\_  
Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Is patient eligible for Medicare?  No  Yes **Please attach copies of patient's insurance cards, if available.**

## 2 PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_  
Office Contact \_\_\_\_\_  
Clinic / Hospital Affiliation \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
E-mail address \_\_\_\_\_  
NPI No. \_\_\_\_\_ License No. \_\_\_\_\_  
DEA No. \_\_\_\_\_  
Physician Medicaid UPIN No. \_\_\_\_\_  
**MD Specialty (required)** \_\_\_\_\_

To reach your team, call toll-free 1 888 608-9010.  
**Please fax completed form to your drug therapy team**  
**1 888 302-1028.**

## 3 CLINICAL INFORMATION

### Primary ICD-9 Code:

**Patient Height** \_\_\_\_\_ in/cm

**Patient Weight** \_\_\_\_\_ lb/kg

Planned schedule of treatment: Is this part of a multidrug regimen? Y ( ) N ( )

Indicate Regimen: MOPP ( ) BEACOPP ( ) Other \_\_\_\_\_

Number of cycles planned \_\_\_\_\_

Current cycle number \_\_\_\_\_

**\*\*\*Please complete all info above to prevent any delay in shipment\*\*\***

**Rx: Matulane**

Strength(s) **50mg** \_\_\_\_\_

Dose: \_\_\_\_\_

Directions (Include daily, weekly, cyclic, one-time, duration of therapy, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

Quantity: \_\_\_\_\_ (# of 50mg capsules) Refills: \_\_\_\_\_

Known Drug Allergies: \_\_\_\_\_

EXPECTED DATE OF FIRST/NEXT DOSE: \_\_\_\_\_ Date of Last Dose? \_\_\_\_\_

Deliver product to:  Office  Patient's Home  Clinic  Clinic Location

If shipped to physician's office, physician accepts on behalf of patient for administration in office

*By signing below, I certify that the above therapy is medically necessary.*

**Prescriber's Printed Name** \_\_\_\_\_

**Prescriber's Signature (sign below)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Dispense as Written**

(Physician attests this is his/her legal signature. **NO STAMPS**)

**Substitution Allowed**