Eligard Enrollment Form

1. **PLEASE FILL OUT AND FAX TO: 718-360-9655**

Or Call 718-556-0942

Patient Information ☐ New Rx ☐ Refill

Name: ______________________ Phone #1: ______________ Phone #2: ______________

Address: ______________________ Allergies: ______________________ ☐ No Known Allergies

City: ______________ ST: ____ Zip: ______ Health Conditions: ______________________

Date of Birth (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___ Expected Start Date: ___ ___/___ ___/___ ___

Statement of Medical Necessity

Patient Weight: ______ ☐ lbs ☐ kg Primary Diagnosis: ______________ **ICD10 Code:** ______________

☐ Last Prescribed Date if Patient has used this medication before: ___ ___/___ ___/___ ___ Duration: ______________

☐ Other medications used to treat this condition: ______________ ☐ Bone density (DEXA) ____% Date completed: ___ ___/___ ___/___ ___

______________________ Date of last negative pregnancy test (if applicable): ___ ___/___ ___/___ ___

Drug Delivery Information

If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

☐ In Office Delivery ☐ Home Delivery for Self Injection/Administration ☐ Home Delivery for Home Health Administration

Other: ______________________

Contact: ______________________

Phone #: ______________________

Address: ______________________

Insurance Information

Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: ______________________ Secondary: ______________________

Insured: ______________________ Insured: ______________________

ID #: ______________ Group #: ______________ ID #: ______________ Group #: ______________

Phone #: ______________ Rx Drug Card #: ______________ Phone #: ______________ Rx Drug Card #: ______________

Rx Bin #: ________ Rx PCN #: ____ Rx Grp #: ______ Rx Bin #: ________ Rx PCN #: ____ Rx Grp #: ______

Doctor/Prescriber Information

NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: ______________________ Office Contact: ______________________

Address: ______________________ NPI #: ______________ DEA #: ______________

City: ______________ ST: ____ Zip: ______ Phone #: ______________ Fax #: ______________

2. **COMPLETE THE FOLLOWING Rx FORM AND PLEASE SEND ELECTRONIC OR HARD COPY Rx**

Rx

Date: ___ ___/___ ___/___ ___

Drug Name/Form/Strength	Directions for Use
☐ 7.5 mg Syringe SC Every Month ☐ 22.5 mg Syringe SC Every 3 Months ☐ 30 mg Syringe SC Every 4 Months ☐ 45 mg Syringe SC Every 6 Months	
Other:	**Quantity:** ________ **Refills:** ________

X ______________________
Doctor/Prescriber Signature – Dispense as Written
Stamped signatures cannot be accepted

X ______________________
Doctor/Prescriber Signature – Substitution Permissible
Stamped signatures cannot be accepted