

YARGESA PATIENT ENROLLMENT FORM

1 PATIENT INFORMATION
(Please complete the following information)

Patient Name (First, MI, Last): _____ DOB: _____ Gender: Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Patient Phone Number: _____ Phone: _____ Please attach demographic information

2 INSURANCE INFORMATION Please attach front and back of patient's insurance card, prescription card, and/or Medicaid card.

Primary Insurance Name: _____	Secondary Insurance Name: _____
Primary Insurance ID: _____	Primary Insurance ID: _____
Insurance Phone Number: _____	Insurance Phone Number: _____
Policyholder Name: _____	Policyholder Name: _____

3 CLINICAL INFORMATION Please fax clinical documentation to pharmacy along with referral form.

Primary ICD-10 Code: _____ Secondary ICD-10 Code: _____

NKDA Drug Allergies _____

Patient Weight: _____ lb kg

Concurrent Medications: _____

4 PRESCRIBER INFORMATION

Practice Name: _____

Prescriber Name: _____ Specialty: _____ NPI: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Office Contact: _____ Phone: _____ Fax: _____

5 PRESCRIPTION INFORMATION

Yargesa capsules 100mg	May Substitute	May NOT Substitute
Take 100mg by mouth three times daily	Qty: <u>30 Day Supply</u>	Refill: _____
Other: _____	_____	
Physician's Signature	Date of Signature	

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