

DEFLAZACORT PATIENT ENROLLMENT

1 PATIENT INFORMATION

(Please complete the following information)

Please attach demographic information

Patient Name (First, MI, Last): _____ DOB: _____ Gender: Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Patient Phone Number: _____
 Parent/Caregiver Name (First, MI, Last): _____ Parent/Caregiver Phone Number: _____

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.

ICD-10 Diagnosis Code: G71.01 Duchenne Muscular Dystrophy Other ICD-10 Code: _____
 NKDA Drug Allergies _____
 Patient Weight: _____ lb kg Date Weight Obtained: _____ Date of Last Clinic Visit: _____

4 PRESCRIBER INFORMATION

Practice Name: _____

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

5 PRESCRIPTION INFORMATION

Deflazacort (Recommended dose: 0.9 mg/kg/day)

Directions for use: Check one option

- Deflazacort Tablets (6mg, 18mg, 30mg, 36mg)
 Deflazacort Oral Suspension (22.75mg/mL)

Dose: Choose one

- Take 0.9 mg/kg orally once daily
 Take _____ mg orally once daily
 Other Directions _____

Dispense: 30 Day Supply Refills: 1 year

6 PHYSICIAN SIGNATURE (Required)

_____ _____
 PRODUCT SUBSTITUTION PERMITTED DATE OF SIGNATURE DISPENSE AS WRITTEN DATE OF SIGNATURE

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