

# Daraprim (pyrimethamine)

## PRESCRIPTION & ENROLLMENT FORM

New patient  Current patient

### PATIENT INFORMATION (Include the front and back copy of the patient's insurance card)

Patient name \_\_\_\_\_  
Date of birth \_\_\_\_\_  Male  Female  
Street address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Parent/guardian (if applicable) \_\_\_\_\_  Principle contact  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Cell phone \_\_\_\_\_ Evening phone \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Insurance company name \_\_\_\_\_  
Insurance company phone # \_\_\_\_\_  
Insured name \_\_\_\_\_  
Insured employer \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Identification # \_\_\_\_\_ Policy/group # \_\_\_\_\_  
Prescription card  No  Yes If yes, carrier \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Eligible for Medicare?  No  Yes Eligible for Medicaid?  No  Yes

### PRESCRIBER INFORMATION

Date \_\_\_\_\_ Time \_\_\_\_\_  
Prescriber name \_\_\_\_\_  
Prescriber practice title \_\_\_\_\_  
Street address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
License # \_\_\_\_\_ DEA # \_\_\_\_\_  
Physician Medicaid UPIN # \_\_\_\_\_ NPI# \_\_\_\_\_  
MD specialty \_\_\_\_\_

Note: This form is intended for prescriber use only.

If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

### CLINICAL INFORMATION

ICD-9 code: \_\_\_\_\_ ICD-10 code: \_\_\_\_\_  
Has the patient ever had megaloblastic anemia due to folate deficiency (contraindication)?  No  Yes  
Does the patient suffer from malabsorption syndrome, alcoholism or take any medications that may lower folic acid levels?  No  Yes  
Is the patient pregnant?  No  Yes  
 NKDA  Known drug allergies \_\_\_\_\_

### PRESCRIBING INFORMATION

Daraprim (pyrimethamine) 25mg tablets Quantity \_\_\_\_\_ Refills \_\_\_\_\_  
Directions \_\_\_\_\_  
Anticipated start date \_\_\_\_\_ Anticipated duration \_\_\_\_\_  
Deliver product to:  Office  Patient home  Clinic  Other  
Clinic location \_\_\_\_\_  
Concurrent Sulfa usage?  No  Yes If Yes, product? \_\_\_\_\_

### PRESCRIBER SIGNATURE

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

Physician printed name \_\_\_\_\_  
Physician signature \_\_\_\_\_ Date \_\_\_\_\_  
(No stamps) (Dispense as written)  
Physician signature \_\_\_\_\_ Date \_\_\_\_\_  
(No stamps) (Substitutions permitted)

This prescription is valid only if transmitted by means of a facsimile machine directly from the prescriber's office or place of practice.

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.