Daraprim (pyrimethamine)

PRESCRIPTION & ENROLLMENT FORM

☐ New patient ☐ Current patient

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).

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 _____

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.