Matulane (procarbazine hydrochloride)

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

Secondary ICD-10: _____ Other _____
Patient height _____ ☐ in ☐ cm Patient weight _____ ☐ kg ☐ lbs
Planned schedule of treatment: Is this part of a multidrug regimen? ☐ Yes ☐ No
Indicate regimen ☐ MOPP ☐ BEACOPP ☐ Other _____
Number of cycles planned _____ Current cycle number _____
☐ NKDA ☐ Known drug allergies _____

PRESCRIBING INFORMATION

Matulane (procarbazine hydrochloride) 50mg capsules (NDC 54482-054-01)
Dosage: _____
Directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.)
_____
_____
Quantity (number of 50 mg capsules) _____ Refills _____
Expected date of first/next dose _____ Date of last dose _____
Deliver product to: ☐ Office ☐ Patient home ☐ Clinic ☐ Other
Clinic location _____

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.