Phospholine Iodide® (echothiophate iodide for ophthalmic solution) 0.125%

PRESCRIPTION & ENROLLMENT FORM

☐ New patient ☐ Current patient

How long has the patient been on therapy: _____

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-10 code: _____

☐ NKDA ☐ Known drug allergies _____

PRESCRIBING INFORMATION

Phospholine Iodide (echothiophate iodide for ophthalmic solution) 0.125%

Quantity _____ Refills _____

Directions _____

Anticipated start date _____ Anticipated duration _____

Deliver product to ☐ Office ☐ Patient home ☐ Clinic ☐ Other

Clinic location _____

PHOSPHOLINE IODIDE QUICKSTART PROGRAM

If there is a delay in verifying insurance coverage, I authorize the Phospholine Iodide QuickStart Program pharmacy to dispense a free initial supply of Phospholine Iodide to eligible patients. Terms and Conditions apply.

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Dosage: _____

Shipping instructions: _____

Deliver product to: ☐ Patient home ☐ Other

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.