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| Fax Referral To: **814-283-2211** | | | | | | | | | | | **1333 Plank Road, Suite 200, Duncansville, PA 16635**  **ColciGel™ Enrollment Form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone 855-265-8008 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ship to:  Patient  Office  Other | | | | | | | | | | | Date: | | | |  | | | | | | |  | | Needs by date | | | | |  | | |  | Is patient new to this therapy? **YES**  **NO** | | | | | | | | | | |
|  | | | | | | | | | | |  | | | |  | | | | | | |  | |  | | | | |  | | |  |  | | | | | | | | | | |
| **Documents necessary for**  **facilitation of referral:** | | | | | | | | | 1. **Enrollment form** 2. **Front/Back copies of all insurance/prescription cards** 3. **Copy of most recent labwork and medication profile** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | PRESCRIBER INFORMATION | | | | | | | | | | | | | | | | | | | | | | | |
| *(Complete the following or* ***send patient demographic sheet****)* | | | | | | | | | | | | | | | | | | | | Prescriber’s Name: | | | | | | | |  | | | | | | | | | | | | | | |  |
| Patient Name: | | |  | | | | | | | | | | | | | | |  | | NPI #: | | | | | | | |  | | | | | |  | |  | | | | |  | |  |
| Address: | | |  | | | | | | | | | | | | | | |  | | DEA #: | | | | | | | |  | | | | | |  | | State License #: | | | | |  | |  |
| City, State, Zip: | | |  | | | | | | | | | | | | | | |  | | Group or Hospital: | | | | | | | |  | | | | | | | | | | | | | | |  |
| Home Phone: | | |  | | | | | | | | | | | | | | |  | | Address: | | | | | | | |  | | | | | | | | | | | | | | |  |
| Alternate Phone: | | |  | | | | | | | | | | | | | | |  | | City, State Zip: | | | | | | | |  | | | | | | | | | | | | | | |  |
| SS #: | | |  | | | | | | | | | | | | | | |  | | Phone: | | | | | | | |  | | | | | |  | | Fax: | |  | | | | |  |
| Date of Birth: | | |  | | | | Gender: | | |  | | | | | | | |  | | Contact Person: | | | | | | | |  | | | | | | | | | Phone: | | |  | | |  |
|  | | |  | | | | | | | | | | | | | | |  | |  | | | | | | | |  | | | | | | | | | | | | | |  | |
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| STATEMENT OF MEDICAL NECESSITY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diagnosis:** | |  | | | | | | | | | | **Additional Clinical Information:** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | Please include diagnosis name and ICD-10: | | | | | | | | | |  | Weight: | | | | |  | | | | | kg/lbs • Height: | | | | | | | | |  | | | | | | | | in/cm | | | | |
|  |  | | | | | | | | | |  | Allergies: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | |  | Failed Therapies: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | |  | Dates of previous therapies: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | |  | Reason(s) for discontinuation: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  |
| • Date of Diagnosis: | | | |  | | | |  | | | |  | Desired start date of therapy: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | |  | | | |  | | | |  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **PRESCRIPTION INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ColciGelTM - 2 Pak**  **30 ml (2 bottles of 15 ml each) = 120 doses (0.25 ml a pump)**  **NDC- 35781-0400-4** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Apply 1-4 pumps up to four times per day.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Prescription notes:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | |  | | | | This prescription will be filled generically unless prescriber writes “DAW” in the box to the right | | | | | | | | | |  | | | | | | | |  |
|  | Physician Signature (Date) | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | |  | | | | | | | |  |