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ENROLLMENT FORM

Today's Date: _____
 Needed By: _____

Last update 10.31.2018



www.commcarepharmacy.com
 Plantation, FL
 Phone: 888.203.7973
 Fax: 888.203.7980
 NCPDP: 1079638
 NPI: 1598762015

Patient Demographics: (Please provide the following or attach demographics sheet)		Provider Office: (Please provide as much information as possible)	
Patient Name: _____		Prescriber's Name: _____ Group/Hospital: _____	
Address: _____		Specialty: _____ License#: _____ Tax ID#: _____	
City, State, Zip: _____		Address: _____	
Preferred Phone: _____ Alt. Phone: _____		NPI: _____ DEA: _____	
Last four digits of SS#: _____ Date of Birth: _____		City, State, Zip: _____	
Gender: _____ Allergies: _____ Height: _____ Weight: _____		Phone: _____ Fax: _____ Office Contact: _____	

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) Always to Physician's Office Alternate Site: (enter below)

Clinical Name: _____	Contact Name: _____
Address: _____	Phone: _____ Fax: _____
Suite: _____ City: _____	State: _____ Zip: _____

Patient Eligibility:
 Is your patient pregnant with a singleton and have a history of singleton spontaneous preterm birth (<37 weeks of gestation)? Yes No
 Current Gestational Age: _____ weeks _____ days Date recorded: _____ Is the patient currently receiving Makena? Yes No

ICD-10 Code:

- O09.212 Supervision of pregnancy with history of preterm labor, second trimester
- O09.213 Supervision of pregnancy with history of preterm labor, third trimester
- O09.219 Supervision of pregnancy with history of preterm labor, unspecified trimester
- Other: _____

Note: The ICD-10 codes start with an uppercase "O" which is followed by a zero.

Drug Name	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Makena® Vial (Hydroxyprogesterone Caproate)	<input type="checkbox"/> 250mg/mL	<input type="checkbox"/> Inject 1mL (250mg) intramuscularly every 7 days <input type="checkbox"/> Other: _____ <input type="checkbox"/> Supplies: 18g needle, 3mL syringe, 21mg needle	<input type="checkbox"/> (#4) 1mL vial <input type="checkbox"/> (#1) 5mL vial <input type="checkbox"/> Other _____	
<input type="checkbox"/> Makena® Autoinjector	<input type="checkbox"/> 275mg/1.1mL	<input type="checkbox"/> Inject 1.1mL (275mg) subcutaneously every 7 days <input type="checkbox"/> Other: _____	<input type="checkbox"/> (#4) auto-injectors	
<input type="checkbox"/> Other				

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to Acro Commcare

Physician Signature: _____ DAW (Dispense as Written) **Date:** _____

Patient Support Programs: I authorize Acro Pharmaceutical Services and Commcare Specialty Pharmacy to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation): _____ **Date:** _____

Please select if you would like the patient enrolled in a Manufacturer's Assistance Program

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