Vigabatrin

Patient Enrollment & Prescription Form

P: 1-844-443-6879 F: 1-844-329-2447

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, Ohio.

PATIENT INFORMATION

Patient Name _____

DOB ___/___/_____ SSN _____ Gender_____

Weight _____ Height _____ Phone _____

Address _____

City, State, Zip _____

Cell Phone _____ E-Mail _____

PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM

Insurance Co. Name _____

Insurance Co. Phone _____ Group# _____

Policy Holder Name _____

Policy Holder Employer _____

Relationship to Patient _____

ID# _____ RxBIN _____ PCN_____

PRESCRIBER INFORMATION

Prescriber's Name _____

Practice Name _____

DEA _____ NPI _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Office Contact Person _____

Office Contact EMAIL _____

Prescription Date _____ Date Needed _____

With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber Signature _____

Ship to: ☐Patient ☐Prescriber's Office ☐Discount Drug Mart

PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

Medical Information

Diagnosis ☐ G40.2: Localization-related symptomatic epilepsy & epileptic syndromes with complex partial seizures

☐ G40.82: Epileptic Spasms (infantile)

☐ Other: _____

Date of Diagnosis _____

Current frequency of monthly refractory complex partial seizures or infantile spasms: _____

_____

Drug Allergies _____

Prior and/or Current Seizure Therapies?

****(Please copy and attach a comprehensive medication list to allow screening for potential drug-to-drug interactions)****

	Treatment Name	Dose	Start Date	Stop Date	Current?	Intolerant?
☐ Phenytoin					☐	☐
☐ Clonazepam					☐	☐
☐ Levetiracetam					☐	☐
☐ Sterioids					☐	☐
☐ Valproate					☐	☐
☐ Other					☐	☐
☐ Other					☐	☐
☐ Other					☐	☐

PRESCRIPTION INFORMATION

☐ **Vigabatrin 500mg Tablets** Patient Weight (kg) _____ Date Weighed _____

Directions: _____

Quantity: _____ Days Supply: _____ Number of Refills _____