



P: 1-844-443-6879

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

Vigabatrin

Patient Enrollment & Prescription Form

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?
<input type="checkbox"/> Phenytoin	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Clonazepam	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Levetiracetam	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sterioids	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Valproate	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

PRESCRIPTION INFORMATION

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

Directions: _____

Quantity: _____ Days Supply: _____ Number of Refills _____

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.