Picato® Enrollment Form

PRx

PATIENT INFORMATION

Patient Name: ____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: ____
City: ____________________ State: ________ Zip: ______________

Phone: (_____) - _____ - ________
Email: ____
Preferred method of contact: ☐ Phone ☐ Email
Height: ________ in Weight: ________ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: ______________________________ ID#: _________________________ Group #: _______________ RxBIN: ___________ RxPCN: ___________

PRESCRIBER INFORMATION

Prescriber Name: ____
Address: ____
City: ____________________ State: ________ Zip: ______________
Contact: _______________ Clinic/Hospital Affiliation: ______________

Phone: (_____) - _____ - ________ Fax: (_____) - _____ - ________
License #: ____
NPI #: ____
Medicaid Provider #: ____

PCTORX-20-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ L57.0 Actinic Keratosis
☐ Other: ____________

Affected area(s):

History of therapies tried/failed (please include dates):

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Picato®** (ingenol mebutate)	☐ 0.015% gel	☐ Apply once daily to affected area(s) of face and scalp for 3 consecutive days (new tube should be used for each application) ☐ Other:		
	☐ 0.05% gel	☐ Apply once daily to affected area(s) of body for 2 consecutive days (new tube should be used for each application) ☐ Other:		

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: ______________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____

© PANTHERx Rare, LLC. All rights in the product names of all third-party products appearing in this document, whether or not appearing with the trademark symbol, belong exclusively to their respective owners.