Sancuso® 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 #: ______________________________

SNCORX-20-01

CLINICAL CONSIDERATIONS

Diagnosis: ____________
ICD10: ____________

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

Is patient new to therapy?: ☐ Yes ☐ No

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Sancuso®** (granisetron)	☐ 3.1 mg/24 hour patch	☐ Apply single transdermal patch to the upper outer arm a minimum of 24 hours before chemotherapy. Remove patch a minimum of 24 hours after completion of chemotherapy. Patch can be worn up to 7 consecutive days (depending on the duration of the chemotherapy regimen).		
		☐ 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: ____ /____ / ____

PANTHER RAREx **PHONE**: 855-726-8479 (412-246-9858) **FAX**: 855-246-3986 (412-787-9400) **www.pantherxrare.com**

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