

## Lysodren (mitotane) 500mg tablets

### PRESCRIPTION & ENROLLMENT FORM

New patient  Current patient

Note: This form is intended for prescriber use only.  
If faxed, the fax must come from MD office or hospital  
(should not be faxed by patient).

#### PATIENT INFORMATION (Include the front and back copy of the patient's insurance card)

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_  Male  Female  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Parent/guardian (if applicable) \_\_\_\_\_  Principle contact  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Evening phone \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Insurance company name \_\_\_\_\_ Insurance company phone # \_\_\_\_\_  
Insured name \_\_\_\_\_ Insured employer \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Identification # \_\_\_\_\_ Policy/group # \_\_\_\_\_  
Prescription card  No  Yes If yes, carrier \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Eligible for Medicare?  No  Yes Eligible for Medicaid?  No  Yes

#### PRESCRIBER INFORMATION

Date \_\_\_\_\_ Time \_\_\_\_\_  
Prescriber name \_\_\_\_\_ Prescriber practice title \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
License # \_\_\_\_\_ DEA # \_\_\_\_\_ Physician Medicaid UPIN # \_\_\_\_\_ NPI# \_\_\_\_\_  
MD specialty \_\_\_\_\_ For ARNP, NP, and PA, collaborative physician agreement with: \_\_\_\_\_

#### CLINICAL INFORMATION

ICD-10 code: \_\_\_\_\_ Secondary ICD-10: \_\_\_\_\_ Other \_\_\_\_\_  
Lysodren blood concentration (mg/L): \_\_\_\_\_ Date: \_\_\_\_\_  
Patient weight: \_\_\_\_\_  NKDA  Known drug allergies \_\_\_\_\_

#### PRESCRIBING INFORMATION

Lysodren (mitotane) 500mg tablets  
Directions: \_\_\_\_\_  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_  
Shipping instructions: \_\_\_\_\_  
Deliver product to:  Patient home  Other

#### PRESCRIBER SIGNATURE

**By signing below, I certify that the prescribed therapy is medically necessary.**

Physician printed name \_\_\_\_\_  
Physician signature \_\_\_\_\_ Date \_\_\_\_\_ (No stamps) (Dispense as written)  
Physician signature \_\_\_\_\_ Date \_\_\_\_\_ (No stamps) (Substitutions permitted)

This prescription is valid only if transmitted by means of a facsimile machine directly from the prescriber's office or place of practice.

**Phone: 800-320-2112 Fax: 866-889-1510**

\*\*\* THIS FORM IS NOT VALID IN THE STATE OF ALABAMA \*\*\*

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.

# **allianceRx**

*Walgreens* Pharmacy

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