

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
Dosage: _____
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.

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