

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Metopirone (metyrapone USP) 250mg capsules

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 _____
Other lab tests completed: _____ Date: _____
Patient weight: _____ NKDA Known drug allergies _____

PRESCRIBING INFORMATION

Metopirone (metyrapone USP) 250mg capsules (Must be dispensed in quantities of 18)
Dosage: _____
Shipping instructions: _____
Deliver product to: Patient home Other

METOPIRONE FASTSTART PROGRAM

If there is a delay in verifying insurance coverage, I authorize the METOPIRONE FastStart Program pharmacy to dispense a free initial supply of METOPIRONE to eligible patients.
Terms and Conditions apply.

Metopirone (metyrapone USP) 250mg capsules
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.

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

Phone: 800-320-2112

Fax: 866-889-1510