Express Health Mart Pharmacy
1173 Nostrand ave,
Brooklyn, NY 11225

Actiq® Enrollment Form

Tel: 347-221-1100
E-Fax: 347-221-1919
E-mail: ehmpharmacy@gmail.com
www.expresshealthmart.com

Date: _____ **Needs by Date:** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
Secondary Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

DIAGNOSIS: _____ • Date of Diagnosis: _____
Secondary Diagnosis (if applicable): _____

Prior (FAILED) Medications:

☐ At least 60mg of morphine per day for a week or longer
☐ At least 25mcg/hour of transdermal fentanyl (Duragesic®) for a week or
☐ Other opioid with an equianalgesic dose (to morphine/trans. Fentanyl) for a week or longer.

Medication: _____
Strength: _____

Injection Training/Home Health Coordination:

• Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary. ☐Yes ☐ No *Agency of choice: _____
• Injection training is not necessary. Date training occurred: _____
Reason: ☐MD office trained ☐Patient already independent ☐Referred by MD to alt. trainer

Patient Evaluation:

• Is patient 16 years of age or older? ☐ Yes ☐ No
• Are there children living in the home? (Medication potentially fatal to children if ingested.) ☐ Yes ☐ No
Pharmacy will counsel patient regarding dangers to children, inadvertent exposure, and disposal of drug unit.
• Concomitant Medications: _____
• Allergies: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Actiq®	☐ 200mcg ☐ 400mcg ☐ 600mcg ☐ 800mcg ☐ 1200mcg ☐ 1600mcg	☐ Place 1 unit between cheek & gums for 15 minutes every _____ hours as needed for pain. ☐ Other: _____	_____ units	0 (CII)

• Actiq® Welcome Kit given to patient by office? ☐ Yes ☐ No

Please Note: A complimentary drug unit child-resistant disposal container will be delivered with the medication. (If welcome kit not given.)

****PLEASE NOTE:** ***DUE TO CONTROLLED SUBSTANCE LAWS, THIS ORIGINAL PRESCRIPTION/ENROLLMENT IS REQUIRED TO BE MAILED TO AND RECEIVED BY THE PHARMACY AT THE ABOVE ADDRESS BEFORE THE MEDICATION CAN BE DISPENSED.***

Ancillary Supplies and Kits Provided As Needed for Administration

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)