Cardiology Enrollment Form

Please fax the completed form to:

601-420-4040

Signature Care Program

2506 Lakeland Drive
Flowood, MS 39232
Phone: 866-420-4041
Fax: 601-420-4040
www.transcriptpharmacy.com

Delivery Need By: Delivery to: ☐ Patients Home ☐ Physician's Office ☐ Other

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐ Female ☐ Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION	
Diagnosis:	Has the patient been treated previously for this condition? ☐ Yes ☐ No
ICD-10 Code:	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Praluent®	☐ Injection Single-Dose Pen 75mg/ml ☐ Injection Single-Dose Pen 150mg/ml	☐ Specified:	☐ 4 week supply ☐ Other:	
Repatha®	☐ Injection: 140mg/ml solution in a single-use prefilled syringe ☐ Injection: 140mg/ml solution in a single-use prefilled SureClick® autoinjector ☐ Injection: 420 mg/3.5ml solution in a single-use PushtronexTM system (on-body infuser with prefilled cartridge)	☐ Specified:	☐ 4 week supply ☐ Other:	
Other:				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Office Contact Name: _______________________________ Preferred phone number & extension: ____________________

Physician Signature: ________________________________ Date: __________

E-Scribe Rx and Fax this Form to 601-420-4040

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