Sucraid® Enrollment Form

Phone: 866-740-2743 (CSID) Fax: 866.777.7097

Patient				Prescriber			
Last Name		First Name		Today's Date			Date Needed
Home Phone Number ( )		Work Phone Number ( )		Prescriber			NPI#
Home Address	City	State	Zip	Address	City	State	Zip
Shipping Address (if different from home address)	☐ Physician	☐ Home	☐ Other	Phone Number ( )		Fax Number ( )	
Date of Birth				Office Contact			
Language Preference ☐ English ☐ Spanish ☐ Other				Preference: ☐ Fax ☐ Phone ☐ Email Email			
Allergies		Patient Weight		Special Instructions			

INSURANCE INFORMATION
(fill out entirely or fax a copy of patient's insurance card, *both sides*)

Primary Insurance:____________________

Insured:____________________

Policy #:____________________

Group #:____________________

Phone #:____________________

Rx Drug Card #:____________________

Secondary Insurance:____________________

Insured:____________________

Policy #:____________________

Group #:____________________

Phone #:____________________

Rx Drug Card #:____________________

Statement of Medical Necessity

Primary Diagnosis: ____________________

ICD9 Code: ____________________

Estimated Start of Therapy: ____________________

Medical History: ____________________

TAPE PRESCRIPTION HERE PRIOR TO FAXING REFERRAL OR COMPLETE THE FOLLOWING:

☐ Sucraid 8500 units/ml (2 x 118 ml).

Sig:____________________

Qty:________ Dose(s) Refills x________ month(s)

Medication:____________________

Sig:____________________

Qty:________ Dose(s) Refills x________ month(s)

Medication:____________________

Sig:____________________

Qty:________ Dose(s) Refills x________ month(s)

Medication:____________________

Sig:____________________

Qty:________ Dose(s) Refills x________ month(s)

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS

Physicians Signature: ____________________ UPIN/DEA #: ____________________ State License#: ____________

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