TotalCare
Otrexup™ (methotrexate) injection Support Program

ENROLLMENT FORM

Customer Service: (855) 820-9605
PLEASE FAX COMPLETED FORM TO: (855) 820-9608

*Indicates required field

PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

*NPI #:

*Prescriber Phone #: *Fax #:

*Address:

*City: *State: *Zip:

*Email:

Office Contact Name:

PATIENT INFORMATION

*Patient Name (Last, First):

*Date of Birth: Gender: M ☐ F ☐

*Address:

*City: *State: *Zip:

*Phone #: Cell #:

Email:

*Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Fill at Preferred Pharmacy

If patient prefers a specific pharmacy, complete ALL the fields.

Pharmacy Name:

Address: City: Zip:

Phone #: Fax:

PATIENT INSURANCE INFORMATION/ PHARMACY BENEFIT PLAN

Please complete all fields below with the patient's pharmacy benefit information, or include copy of front AND back of prescription benefit card.

*Insurance Name: Pharmacy Help Desk #:

Policyholder Name: *Relationship to Patient:

*Member ID #: *Group ID #:

*Rx BIN #: *PCN #:

Special Instructions/Supplemental Insurance:

PRESCRIPTION INFORMATION

*Patient Name (Last, First):

Drug: **Otrexup (methotrexate) Injection**
(Check box options listed below:)

☐ 7.5mg/0.4mL ☐ 10mg/0.4mL ☐ 12.5mg/0.4mL
☐ 15mg/0.4mL ☐ 17.5mg/0.4mL ☐ 20mg/0.4mL
☐ 22.5mg/0.4mL ☐ 25mg/0.4mL

*Weight: ☐ kg ☐ lbs Date Collected:

*Height: ☐ cm ☐ inches BSA:

*Quantity: *Refills:

*Directions:

PATIENT DIAGNOSIS

☐ M06.9 Rheumatoid Arthritis
☐ M08.00 Polyarticular Juvenile Idiopathic Arthritis
☐ L40.0 Psoriasis

☐ ICD-10 Code/ Description:

*Please list any known allergies to medication or other substances:

PROVIDER ATTESTATION

By my signature below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that Asembia Specialty Pharmacy Network (ASPN) reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize ASPN as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow ASPN to email me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

☐ **Please send me status updates via email.** You may opt-in to receive e-mails from ASPN regarding the status of your patient's prescription. By agreeing to receive e-mails from ASPN, you acknowledge that ASPN will send standard e-mails to you via the Internet. Therefore, there is potential for these unencrypted emails to be intercepted by unauthorized third parties. If you share your e-mail account or computer with others, those parties may be able to access your confidential information. You should notify ASPN immediately if you wish to cease receiving e-mails or if your e-mail address changes. You should not use e-mails for emergencies.

*Prescriber's Signature

(Dispense As Written)

*Date of Signature

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