Reset Form

Prescription and Patient Enrollment Form

eucrisa
crisaborole ointment 2%

eucrisa·4·you
patient savings & support

Please complete and fax pages 1 and 2 of this form, along with fax cover sheet, to eucrisa•4•you at 1-877-548-1734. For assistance or additional information, call 1-844-EUCRISA (1-844-382-7472), Monday-Friday, 8 AM to 8 PM ET.

1. PATIENT INFORMATION You may also fax demographics/face sheet (To be completed by the patient)

First Name _____ Last Name _____

Home Address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ DOB (mm/dd/yyyy)_____ Gender: ☐ M ☐ F

Email _____ Preferred Language (if not English) _____

☐ Patient has a Caregiver Caregiver Name _____ Caregiver Phone _____

2. CLINICAL INFORMATION (To be completed by the healthcare provider)

Primary Diagnosis _____ ICD-10 _____ Secondary Diagnosis _____ ICD-10 _____

3. PRESCRIPTION INSURANCE INFORMATION (To be completed by the patient or healthcare provider)
Please include copies of both sides of patient's insurance card(s)

☐ **CHECK HERE IF PATIENT DOES NOT HAVE INSURANCE** ☐ **CHECK HERE IF PATIENT HAS SECONDARY INSURANCE**

Primary Insurance

Primary Insurance Name _____ Primary Insurance Phone Number _____

Policyholder Name _____ Policy # _____ Group # _____

Policyholder Relationship to Patient _____ Policyholder DOB _____

Prescription Insurance

Prescription Insurance _____ Rx Policy ID # _____

Rx Group ID # _____ Rx BIN _____ Rx PCN _____

If Medicare Part D is selected, enter the Medicare Part D address

Street Address _____ City _____ State _____ ZIP _____

Preferred Pharmacy and Address _____ ☐ Self-Dispensing Pharmacy

The patient identified above prefers use of the pharmacy indicated above. I authorize Pfizer and its affiliates, agents, representatives, and service providers to fax this prescription to the pharmacy designated above, provided it is approved by this patient's plan. If the pharmacy designated is not a plan-approved pharmacy, then to a pharmacy approved by this patient's plan. If there is no preferred pharmacy indicated, then to any pharmacy approved by this patient's plan.

4. HEALTHCARE PROVIDER INFORMATION (All fields must be completed by the healthcare provider)

Prescriber Name (First/MI/Last) _____ Specialty _____ State License Number _____

Practice Name _____ NPI# _____

Street Address _____ City _____ State _____ ZIP _____

Office Contact _____ Phone Number _____

Fax Number _____ Email _____

5. PRESCRIPTION Directions for ePrescribing are located at the bottom of this page

Prescription for EUCRISA (crisaborole) ointment, 2%

☐ 60-g tube ☐ 100-g tube Quantity _____ Refills _____

Directions for Use (please include location on the body)

_____

6. HEALTHCARE PROVIDER CONSENT Original signature only

Prescriber Signature (REQUIRED) I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary and that the information provided in this form is accurate to the best of my knowledge. I authorize Pfizer, and its affiliates, agents, representatives and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy. If you are a prescriber based in New York state, please use a New York state prescription form.

X _____
Dispense As Written – NO STAMPS **Date**

X _____
Substitution Permitted – NO STAMPS **Date**

Print Name of Healthcare Provider _____

ePrescribe ID #5910206 If you choose to ePrescribe directly to Sonexus Health Specialty Pharmacy, you are certifying that you have received patient consent for Sonexus Health Specialty Pharmacy and eucrisa•4•you to contact your patient and provide them services. Sonexus Health Specialty Pharmacy is categorized as a retail pharmacy in EMR/EHR systems and is located at 2730 S. Edmonds Lane, #400, Lewisville, TX 75067.