Trelstar Enrollment Form

1. PLEASE FILL OUT AND FAX TO: 718-360-9655

Or Call 718-556-0942

Patient Information ☐ New Rx ☐ Refill

Name: _____ Phone #1: _____ Phone #2: _____

Address: _____ Allergies: _____ ☐ No Known Allergies

City: _____ ST: _____ Zip: _____ Health Conditions: _____

Date of Birth (mm/dd/yyyy): __ __ / __ __ / __ __ __ __ Expected Start Date: __ __ / __ __ / __ __

Statement of Medical Necessity

Patient Weight: _____ ☐ lbs ☐ kg Primary Diagnosis: _____ **ICD10 Code:** _____

☐ Last Prescribed Date if Patient has used this medication before: __ __ / __ __ / __ __ Duration: _____

☐ Other medications used to treat this condition: _____ ☐ Bone density (DEXA) ____% Date completed: __ __ / __ __ / __ __

_____ Date of last negative pregnancy test (if applicable): __ __ / __ __ / __ __

Drug Delivery Information If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

☐ In Office Delivery ☐ Home Delivery for Self Injection/Administration Contact: _____

☐ Home Delivery for Home Health Administration Phone #: _____

Other: _____ Address: _____

Insurance Information Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: _____ Secondary: _____

Insured: _____ Insured: _____

ID #: _____ Group #: _____ ID #: _____ Group #: _____

Phone #: _____ Rx Drug Card #: _____ Phone #: _____ Rx Drug Card #: _____

Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____ Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____

Doctor/Prescriber Information NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: _____ Office Contact: _____

Address: _____ NPI #: _____ DEA #: _____

City: _____ ST: _____ Zip: _____ Phone #: _____ Fax #: _____

2. COMPLETE THE FOLLOWING Rx FORM AND PLEASE SEND ELECTRONIC OR HARD COPY Rx

Rx

Date: __ __ / __ __ / __ __

Drug Name/Form/Strength	Directions for Use
☐ 3.75 mg Vial IM Every 4 Weeks ☐ 3.75 mg Syringe IM Every 4 Weeks ☐ 11.25 mg Syringe IM Every 12 Weeks ☐ 11.25 mg Vial IM Every 12 Weeks ☐ 22.5 mg Syringe IM Every 24 Weeks	
Other:	**Quantity:** _____ **Refills:** _____

X _____ X _____

Doctor/Prescriber Signature – Dispense as Written
Stamped signatures cannot be accepted

Doctor/Prescriber Signature – Substitution Permissible
Stamped signatures cannot be accepted