PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Daraprim (pyrimethamine)

PRESCRIPTION & ENROLLMENT FORM

☐ New patient ☐ Current patient

Note: This form is intended for prescriber use only.
If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

Phone: 800-222-4991 Fax: 877-853-3073

PATIENT INFORMATION (Include the front and back copy of the patient's insurance card)

Patient name _____
Date of birth _____ ☐ Male ☐ Female
Street address _____
City _____ State _____ Zip _____
Parent/guardian (if applicable) _____ ☐ Principle contact
Home phone _____ Work phone _____
Cell phone _____ Evening phone _____
E-mail address _____
Insurance company name _____
Insurance company phone # _____
Insured name _____
Insured employer _____
Relationship to patient _____
Identification # _____ Policy/group # _____
Prescription card ☐ No ☐ Yes If yes, carrier _____
Policy # _____ Group # _____
Eligible for Medicare? ☐ No ☐ Yes Eligible for Medicaid? ☐ No ☐ Yes

PRESCRIBER INFORMATION

Date _____ Time _____
Prescriber name _____
Prescriber practice title _____
Street address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
License # _____ DEA # _____
Physician Medicaid UPIN # _____ NPI# _____
MD specialty _____

CLINICAL INFORMATION

ICD-9 code: _____ ICD-10 code: _____
Has the patient ever had megaloblastic anemia due to folate deficiency (contraindication)? ☐ No ☐ Yes

Does the patient suffer from malabsorption syndrome, alcoholism or take any medications that may lower folic acid levels? ☐ No ☐ Yes

Is the patient pregnant? ☐ No ☐ Yes
☐ NKDA ☐ Known drug allergies _____

PRESCRIBING INFORMATION

Daraprim (pyrimethamine) 25mg tablets Quantity _____ Refills _____
Directions _____
Anticipated start date _____ Anticipated duration _____

Deliver product to: ☐ Office ☐ Patient home ☐ Clinic ☐ Other

Clinic location _____

Concurrent Sulfa usage? ☐ No ☐ Yes If Yes, product? _____

PRESCRIBER SIGNATURE

By signing below, I certify that the prescribed therapy is medically necessary.

Physician printed name _____

Physician signature _____ Date _____
(No stamps) (Dispense as written)

Physician signature _____ Date _____
(No stamps) (Substitutions permitted)

This prescription is valid only if transmitted by means of a facsimile machine directly from the prescriber's office or place of practice.

***** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *****

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Walgreens Pharmacy

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