aspn Pharmacies Program

ENROLLMENT FORM

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	Male: ☐ Female: ☐	Circle unit of measure Height (in/cm): _____ Weight (lb/kg): _____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Pharmacy Insurance Information

Insurance Name:	MemberID:	
BIN:	Group:	PCN:

Drug Information

Please select the medication to prescribe:

		NDC	Quantity	Refills
☐	**LAMOTRIGINE Orange Starter Kit** Generic Total 49 Tablets(42 X 25mg) (7 X 100mg)	69102-137-10	1 Kit (49 Tablets)	0
☐	**LAMOTRIGINE Blue Starter Kit** Generic Total 35 Tablets(35 X 25mg)	69102-639-09	1 Kit (35 Tablets)	0
☐	**LAMOTRIGINE Green Starter Kit** Generic Total 98 Tablets(84 X 25mg) (14 X 100mg)	69102-359-11	1 Kit (98 Tablets)	0
☐	**SUBVENITE Orange Starter Kit** Brand Total 49 Tablets(42 X 25mg) (7 X 100mg)	69102-300-01	1 Kit (49 Tablets)	0
☐	**SUBVENITE Blue Starter Kit** BRAND Total 35 Tablets(35 X 25mg)	69102-306-01	1 Kit (35 Tablets)	0
☐	**SUBVENITE Green Starter Kit** BRAND Total 98 Tablets(84 X 25mg)(14 X 100mg)	69102-312-01	1 Kit (98 Tablets)	0

Directions: Take as directed per kit instructions

Prior Authorization

Has your office previously completed a prior authorization for this product?	If YES, outcome:	For DENIALS: Has an appeal been submitted for this denial?	If YES, what was the outcome?
☐ Yes ☐ No	☐ APPROVED (Date: _____) ☐ DENIED* (Date: _____) *Please provide denial #_____for documentation	☐ Yes ☐ No	_____ Date: _____

Prescriber Information

First Name:	Office Email:
Last Name:	NPI#:
Address:	Office Contact:
City:	Office Phone:
State: Zip:	Office Fax:

Prescriber Signature Required

_____ _____

(Stamp Signature Not Allowed) Electronically signed **Date:**

☐ **Do Not Substitute**

_____

Prescriber's Initials

FOR A PRESCRIPTION TO BE VALID, A SIGNATURE AND INITIALS ARE BOTH REQUIRED FOR DO NOT SUBSTITUTE

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