PAIN MANAGEMENT ENROLLMENT FORM

24 Wellness Rx

DATE: ____________________ SHIP TO: ☐ PATIENT ☐ OFFICE
DATE NEEDED: ____________________

PATIENT INFO

NAME ____________ E-MAIL____________ DOB____________ ☐ MALE ☐ FEMALE
ADDRESS____________ CITY____________ STATE______ ZIP__________
HOME TELEPHONE ____________ MOBILE PHONE____________ SS#____________

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

DATE OF DIAGNOSIS:____________ ALLERGIES: ____________
DIAGNOSIS CODE: ____________ OTHER: ____________

PRESCRIPTION INFORMATION

☑ **CHECK BOX FOR APPLICABLE PRESCRIPTION**

DRUG / DOSAGE FORM/STRENGTH	QTY	REFILLS
☐ Anti-Inflammatory Pain Diclofenac 10% topical _____gel ______cream	☐ 60g ☐ 120g ☐ 240g ☐ 300mg ☐ Other_______	
☐ Anti-Inflammatory Pain Ketoprofen 10% cream	☐ 60g ☐ 120g ☐ 240g ☐ 300mg ☐ Other_______	
☐ Neuropathic Pain Baclofen 5%, Ketoprofen 10% , Lidocaine 5%, Gabapentin 5% Cream	☐ 60g ☐ 120g ☐ 240g ☐ 300mg ☐ Other_______	
☐ Neuropathic Pain Ketamine 10%, Gabapentin 6% Clonidine, 0.2%, Transdermal Cream	☐ 60g ☐ 120g ☐ 240g ☐ 300mg ☐ Other_______	
☐ Neuropathic Pain Amitriptyline HCI 2%/Baclofen 5%/Ketamine HCI 5%/ Ketoprofen 10% Transdermal Cream	☐ 60g ☐ 120g ☐ 240g ☐ 300mg ☐ Other_______	
☐ General Pain ___________ %, Gabapentin 6%, Baclofen 2%, Cyclobenzaprine 2% Cream (must write Ketamine – normal concentration 0.5% - 20%)	☐ 60g ☐ 120g ☐ 240g ☐ 300mg ☐ Other_______	
☐ Fibromyalgia, MS, Crohn's Naltrexone Capsule Capsule taken nightly	______4.5 mg capsule, __________ ☐ Other_______	

Diclofenac	________%	**Tetracaine**	________%	**Flurbiprofen**	________%	**Baclofen**	________%
Ibuprofen	________%	**Cyclobenzaprine**	________%	**Ketoprofen**	________%	**Gabapentin**	________%
Meloxicam	________%	**Amitriptyline**	________%	**Benzocaine**	________%	**Carbamazepine**	________%
Bupivacaine	________%	**Imipramine**	________%	**Lidocaine**	________%	**Acyclovir**	________%
Prilocaine	________%	__________	________%	__________	________%	__________	________%

(Must Write Ketamine) **Typical SIG: Apply 1 - 2 GRAMS to affected area 4 - 6 times daily (max 12 grams daily)**

QTY: ☐ **90gm** ☐ **120gm** ☐ **240gm** ☐ **300gm** ☐ ____ **gm** **REFILLS: PRN** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ ___

**All Ingredients to be compounded in transdermal cream base vehicle*

PRESCRIBER INFORMATION

Prescriber's Name: ____________ Contact Person:____________
Telephone: ____________ Fax:____________ Email:____________
Office Address: ____________ City:____________ State: ______ Zip:________
NPI # : ____________ DEA # : ____________ TAX ID # : ____________ Medicaid Provider # :____________

____________ ____________ * ____________
PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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