



Total Care Rx Enrollment Form

Date _____ - _____ - _____
Month Day Year

A prescription of PANCREAZE (pancrelipase) extended release capsules _____ (Strength)

2,600 lipase unit 4,200 lipase unit 10,500 lipase unit 16,800 lipase unit 21,000 lipase unit

Quantity of capsules: _____ Number of refills: _____ Number of capsules per meal: _____ Number of capsules per snack: _____

Patient Information:

Patient Name: _____ Phone: _____ Date of Birth: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Allergies: _____ Diagnosis: _____

Patient Insurance Information for Prescription

Insurance Plan Name: _____

ID#: _____ Group #: _____

RX BIN #: _____ RX PCN #: _____

Insurance Plan Phone: _____

Name of Person Insured: _____

Physician Information:

Physician Name: _____ Specialty: _____

DEA#: _____

Clinic Name: _____ Phone: _____


Clinic Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Physician's Original Signature: **X** _____


Please Note: Signature stamps and e-signatures are not permitted.

1




Please fill out and complete the form

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Fax completed form to **Total Care Rx** at **718-504-7426**

OR



E-Scribe to **Total Care Rx**
 223-10 Union Turnpike
 Oakland Gardens NY 11364

Submit this form to Total Care Rx:

FAX to 718-504-7426 or send via E-scribe

Total Care Rx NPI: 1821329731

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