aureus

Phone: 844-428-7387
Fax: 844-228-7387

Gout Enrollment Form

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

SS#: _____ DOB: _____

Phone: _____ Alt. Phone: _____

Emergency Contact: _____

Allergies: _____

Sex: M F Wt: _____ Ht: _____ Diabetic: Y N

Patient previously on treatment for Gout: Y N

If yes, Date previously treated: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
MD/DO/NP/PA

Address: _____

City, State, Zip: _____

Office Contact: _____

Phone: _____ Fax: _____

NPI: _____

DEA: _____

License: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy#: _____

Insured: _____ Group: _____

Phone: _____ BIN#: _____ PCN#: _____

Please include current patient medication list with referral

MEDICAL ASSESSMENT

- Is patient currently on therapy for Gout? Y N Medications: _____
- Will patient stop taking the above medication(s) before starting the new medication? Y N

  If yes, what is the washout period? _____
- Other medications patient is currently taking including OTC medications with dosage and direction

  (or fax medicaiton profile:) _____

PRESCRIPTION INFORMATION

	Diagnosis Code	Drug Name	Qty	Directions	Refills
☐		ColciGel	___(2) 15 ml bottles	Apply 1-4 pumps up to four times per day.	
☐					
☐					
☐					
☐					
☐					

By signing this form and utilizing our services, you are authorizing Aureus and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: _____ _____ Date: _____

May Substitute Dispense as Written