



20880 W. Dixie Highway, Suite 104
 Aventura, FL, 33180
 Phone: (786) 749-6812
 Fax: (844) 697-4493

Prepare for the Flare™

Now Available through White Glove Rx

Patient Information					
First Name:		M.I.	Last Name:		
DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Email:		
Best Contact Number: []			[circle] Home/Work/Cell		
Alternate Number: []			[circle] Home/Work/Cell		
Home Address: Street			Delivery Address (if different): Street		
City	State	Zip	City	State	Zip

Patient Insurance Information			
Prescription Insurance Provider:			
Policy #:	Group #/RxGRP:	RxBIN:	RxPCN:
Name of Insured:		Relationship to Insured:	

TERMS AND CONDITIONS: Patients must have a valid prescription for ColciGel® (type and day supply bottle). By enrolling, the patient elects to receive the branded product and acknowledges that no generic substitution will be offered (if applicable).

Prescribers
<p>Fax: Complete form and submit to 1-844.697.4493. Upon receipt of Rx, the pharmacy will contact the patient for payment and delivery scheduling.</p> <p>eScribe: Select White Glove Rx in your eScribe system and send electronically. If you need help locating White Glove Rx, please contact your system administrator.</p>

PRESCRIBER AND PRESCRIPTION INFORMATION			
<p>To be completed by prescriber -or- attach your prescription to the lower half of this form, -or- ePrescribe to <i>White Glove Rx</i> Aventura, FL 33180</p>	<div style="text-align: center;"> <p>COLCIGEL® - 2 PAK 30mL (15mL x 2 Bottles) = 120 Doses NDC-35781-0400-4</p> <p><input type="checkbox"/> Apply 1-4 pumps up to four times per day.</p> <p>Circle desired refills: 1 2 3 other: ____ Medically necessary for emergency flares.</p> </div>		
	Notes to Pharmacy		
	<table border="1" style="width: 100%;"> <tr> <td>Prescriber Name</td> <td>NPI#</td> </tr> </table>	Prescriber Name	NPI#
	Prescriber Name	NPI#	
	Prescriber Address		
	<table border="1" style="width: 100%;"> <tr> <td>Office Contact Name</td> <td>Prescriber Phone/FAX</td> </tr> </table>	Office Contact Name	Prescriber Phone/FAX
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	Please specify the diagnosis and ICD-9/ICD-10 code:		
	PRESCRIBER SIGNATURE	Date	