TIRF PAIN & SUPPORTIVE CARE **ENROLLMENT FORM**

GREENHILL PLUS+ Specialty Pharmacy Solution
Connection • Care • Community

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

Patient Information

Patient Name _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Home Phone _____ Alternate Phone _____
DOB _____ SSN _____ Gender ○ M ○ F
Weight _____ kg/lbs Height _____ cm/in
Language Preference: ○ English ○ Spanish ○ Other _____
Caregiver Name _____ Relation _____
Local Pharmacy _____ Phone _____
Insurance Plan _____ Plan ID _____
Please fax a copy of front and back of the insurance card(s)

Prescriber Information & Shipping Information

Prescriber's Name _____
NPI _____ DEA _____
Tax ID # _____ Medicaid Provider # _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Contact _____
Phone _____ Alternate Phone _____
Fax _____
Email _____
If shipping to prescriber ○ First Fill ○ Always ○ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis Codes ○ G89.3 Cancer-Associated Pain ○ G89.4 Chronic Pain Syndrome ○ G89.29 Chronic Pain NOS ○ K59.03 Drug-induced Constipation ○ T40.9 Opioid Overdose
○ Date of Diagnosis _____ ○ Other _____

○ Patient is opioid tolerant per TIRF REMS requirement ○ Patient is over the age of 18 ○ **Allergies** ○ Latex ○ Other _____

○ Please document current around-the-clock or extended-release opioid medication(s) the patient is taking

Drug	Dose	Frequency

○ Application site irritation with previous product
○ Patient cannot tolerate previous product due to side effect
○ Inadequate analgesic effect
○ Patient has existing oral complications that complicate/prevent taking oral medications:
○ dry mouth ○ dental carries ○ difficulty swallowing
○ nausea/vomiting ○ mucositis ○ head and neck cancer complication

Medications Tried and Failed (Please check all that apply)

○ Abstral®_____ mcg ○ Actiq®_____ mcg ○ Fentora®_____mcg ○ Lazanda®_____mcg ○ Onsolis®_____mcg ○ Subsys®_____mcg
○ Oral Transmucosal fentanyl citrate/OTFC_____mcg ○ Other _____

TIRF Pain Medications (Please send an e-prescription for the selected medication, or fax a prescription to the pharmacy and arrange for hardcopy delivery)

○ **Abstral® sublingual tablet**
○ **Fentanyl citrate transmucosal lozenge (generic Actiq®)**
○ **Fentora® buccal tablet**
○ **Lazanda® nasal spray**
○ **Subsys® sublingual spray**

NOTE: This is not a prescription for a TIRF product.
As a CII medication, a seperate hardcopy or e-prescription is required. This form is intended to be used as a clinical reference for the prescriber and pharmacy to air in clinical management.

Prescription Information - Non-CII Medications/Supportive Care

Opioid Overdose Prevention

Drugs	Dosage/Strength	Directions	Quantity	Refills
○ **Evzio®**	○ 0.4mg/0.4ml pen *Note: each device contains a single dose*	○ Inject 1 pen IM or SC in thigh and seek immediate medical attention by calling 911; may repeat dose after 2 to 3 minutes as needed. ○ Other_____	○ 2 pens (1 kit)	
○ **Narcan®**	○ 4mg/0.1ml nasal spray *Note: each device contains a single dose*	○ Use one spray in one nostril and seek immediate medical attention by calling 911; may repeat dose after 2 to 3 minutes as needed, alternating nostrils. ○ Other_____	○ 2 bottles (1 kit)	
○ **Other**	○ _____	○ _____	○ _____	_____

Opioid-Induced Constipation

Drugs	Dosage/Strength	Directions	Quantity	Refills
○ **Relistor®**	○ 8mg/0.4ml PFS ○ 12mg/0.6ml PFS ○ 12mg/0.6ml vial ○ 150mg tablet	○ Inject 1 pen refilled syringe SC every OTHER day as needed. ○ Inject _____mg SC every OTHER day as needed. ○ Take 3 tablets (450mg) PO ONCE a day in the morning.	○ 7 PFS (1 kit) ○ _____ vials ○ 90 Tablets	
○ **Other**	_____	_____	_____	_____

Administration Training Provided by: ○ Physician's Office ○ Pharmacy ○ Other: _____
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Ship to: ○ ***Patient*** ○ ***Office*** ○ ***Other*** _____ ***Date*** _____ ***Needs by Date*** _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: _____ _____ ***Date:*** _____
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Supervising Physician / Supervising Physician Signature: _____