



TIRF REMS Pain Management Intake Form

E-Prescribing to AllCare Plus Pharmacy Available

NCPDP 2243880 Toll free (855) 880-1091 Toll free fax (844) 265-0265

50 Bearfoot Road, Northborough, MA 01532

www.AllCarePlusPharmacy.com

DATE: _____ THERAPY START DATE: _____ DELIVERY: PATIENT OFFICE OTHER: _____

PATIENT INFORMATION	
Patient Name	
Address	
City, State, Zip	
Phone	
Social Security	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFORMATION	
Prescriber Name	DEA/NPI #
Facility Name	
Address	
City, State, Zip	
Phone	Fax
Office Contact	

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

Plan Name: _____ ID#: _____ Group#: _____ Bin#: _____ Insurance Phone#: _____

CLINICAL INFORMATION

PLEASE E-PRESCRIBE OR MAIL HARD COPY PRESCRIPTIONS IN ORDER TO FULLY PROCESS

TIRF medicines are indicated only for the management of breakthrough pain in adult cancer patients 18 years of age and older (16 years of age and older for Actiq® brand and generic equivalents) who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain.

Diagnosis (ICD-10 Code):

ICD-10 Code: _____ Other ICD-10 Code: _____

ADDITIONAL INFORMATION

LANGUAGE: English Spanish Other _____

ALLERGIES: _____

PRESCRIPTION INFORMATION

DRUG	DOSAGE
<input type="checkbox"/> ABSTRAL® (fentanyl)	<input type="checkbox"/> 100 mcg <input type="checkbox"/> 200 mcg <input type="checkbox"/> 300 mcg <input type="checkbox"/> 400 mcg <input type="checkbox"/> 600 mcg <input type="checkbox"/> 800 mcg
<input type="checkbox"/> FENTORA® (fentanyl buccal tablet)	<input type="checkbox"/> 100 mcg <input type="checkbox"/> 200 mcg <input type="checkbox"/> 400 mcg <input type="checkbox"/> 600 mcg <input type="checkbox"/> 800 mcg
<input type="checkbox"/> SUBSYS® (sublingual spray)	<input type="checkbox"/> 100 mcg <input type="checkbox"/> 200 mcg <input type="checkbox"/> 400 mcg <input type="checkbox"/> 600 mcg <input type="checkbox"/> 800 mcg
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____ Notes: _____

PHYSICIAN SIGNATURE

Physician Signature: _____ Date: _____

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

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. 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. In no event should the material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. This is a patient enrollment form for the above mentioned therapies. Patients have the right to use the Pharmacy of their choice, if AllCare Plus Pharmacy is the Pharmacy of choice, please follow up with a call in, electronic, faxed or mailed prescription to AllCare Plus Pharmacy, 50 Bearfoot Road, Northborough, MA 01532. (Phone) 1 855 880 1091 (Fax) 1 844 265 0265