



# 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     
  37,000 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

**2**



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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