ARTHRITIS PAIN & INFLAMMATION ENROLLMENT FORM

Phone : (832)813-5296
Fax : (832)813-8495

THE WOODLANDS

Patient Name: _____ **DOB:** _____ **Sex** □ **M** □ **F**

Address: _____ **Phone:** _____

Insurance: _____ **ID** _____ **BIN**_____ **PCN**_____

PRESCRIPTION INFORMATION

		DIRECTIONS	Qty	Refills
□	DUEXIS® (ibuprofen and famotidine) Tablets 800 mg/26.6 mg	Take ONE tablet by mouth THREE times a Day	___	___
□	PENNSAID® (diclofenac sodium topical solution) 2% w/w	Apply 2 pumps TWICE times a Day	___	___
□ 2mg □ 5mg	RAYOS® (Prednisone) Delayed-release Tablets	_____	___	___
□ 375/20 □ 500/20	Vimovo® (naproxen/esomeprazole magnesium) 375/20•500/20 mg delayed-release tablets	Take ONE tablet by mouth TWICE times a Day	___	___
□ 18mg □ 35mg	ZORVOLEX® 18 mg 35 mg (diclofenac) capsules	Take ONE tablet by mouth TWICE times a Day	___	___
□ 20mg □ 40mg	Tivorbex™ (indomethacin) capsules	_____ _____	___	___

Diagnosis: _____ **Anticipated Start Date:** _____ **Ship to:** □ **MD** □ **Patient** □ _____

Physician's Name: _____ □ **DAW** *(Dispense as written)* **Date:** _____

Physician's Signature: _____ **DEA:** _____ **Office Contact:** _____

Physician's Address: _____ **Phone:** _____ **Fax:** _____

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

Fax your referral to (855) 822-7838