BLUEGRASS PHARMACY | ACTIQ ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

ICD-10 Code	Description

Prior (failed) Medications:

◯ At least 60 mg of morphine per day for a week or longer

◯ At least 25 mcg/hour of transdermal fentanyl (Duragesic) for a week or longer

◯ Other:

Drug	Strength

Specialty pharmacy to coordinate injection training/home health nurse visits:

◯ Yes ◯ No ◯ Injection training is not necessary

If no, reason:

◯ MD office trained ◯ Referred by MD office to alternate trainer ◯ Patient already independent

Is patient 16 years of age or older? ◯ Yes ◯ No

Are there children in the home? ◯ Yes ◯ No *(Medication is potentially fatal to children if ingested)*

Height (in/cm): Weight (lb/kg):

Allergies:

Concomitant Medications:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Actiq®	◯ 200 mcg ◯ 800 mcg ◯ 400 mcg ◯ 1200 mcg ◯ 600 mcg ◯ 1600 mcg	◯ Place 1 unit between cheek and gums for 15 minutes every _____ hours as needed for pain. ◯ Other:	_____ Units	

Actiq welcome kit given to patient by office? ◯ Yes ◯ No

Note: Due to controlled substance laws, this original prescription form must be MAILED to Bluegrass Pharmacy at the address shown to the right before the medication can be dispensed.

Bluegrass Pharmacy
160 Moore Dr, Ste 105
Lexington, KY 40503

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE