ENROLLMENT FORM

Please fill out this form so the patient can be properly enrolled in the DiasDay Gel Patient Program.

DIASDAYGEL

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth (mm/dd/yyyy) _____ ◯ M ◯ F Sex _____ Email _____

Shipping Address _____ Apt/Bldg/Fl _____ City _____ State _____ ZIP Code _____ Phone # _____ ◯ Permission to Leave Voicemail

Alternative Contact Name _____ Contact Phone # _____ Contact Email _____ Relationship to Patient _____ Preferred Language of Patient *(other than English)* _____

INSURANCE INFORMATION

Policyholder: ◯ Self ◯ Other (Please complete policyholder details below)

Policyholder First Name _____ Policyholder Last Name _____ Relationship to Patient _____

Primary Medical Insurance Name _____ Insurance Phone # _____ Subscriber ID # _____ Group # _____

PRESCRIBER INFORMATION *(please include supervising md or do, where applicable)*

First Name _____ Last Name _____ Specialty _____ Phone # _____ Fax # _____

Practice Name _____ Address _____ City _____ State _____ ZIP Code _____

Prescriber NPI _____ Group NPI (If applicable) _____ Prescriber State License # _____ Tax ID # _____ Office Contact Name _____

Office Contact Phone # _____ Office Contact Email _____ Preferred Method of Communication: ◯ Phone ◯ Email ◯ No Preference

PRESCRIPTION: DIASDAY GEL *5-mL multiple-dose vial containing 80 USP units/mL for intramuscular or subcutaneous use*

A. Please select dose from this list below:

◯ Other dose: _____ units _____ times a _____ Duration: _____

Quantity of 5-mL multi-dose: _____ **Refills:** _____

B. Taper instructions: Special instructions, titration, or taper dose, if applicable

_____

_____

_____

C. Allergies

_____

_____

_____

C. Patient injection training for administering Diasday Gel

◯ By selecting this option, I request complimentary injection training for my patient. I acknowledge that this service offers multiple sessions, either in-person or virtual, solely for the purpose of injection training.

D. Please identify the supplies needed for prescription

Route of administration (injection): ◯ Intramuscular ◯ Subcutaneous

Syringe size	**Needle size for drawing**
◯ 1 mL ◯ 3 mL ◯ Other: _____	◯ 20 G needle, 1" ◯ None
Quantity: _____	**Quantity:** _____

Needle size for injection

◯ 25 G needle, 5/8" ◯ 23 G needle, 3/4" ◯ 23 G needle, 1" ◯ 25 G needle, 1"

◯ Other: _____ **Quantity:** _____

I confirm that the patient and prescriber information on this enrollment form was filled out by me or under my supervision, and that the details provided are complete and accurate to the best of my knowledge. I authorize the DiasDay program to act on my behalf to transmit this prescription to the designated pharmacy. By signing below, I agree to the Prescriber Certification and Statement of Medical Necessity.

_____ _____ **OR** _____ _____

DISPENSE EXACTLY AS PRESCRIBED **DATE** **ALLOW SUBSTITUTIONS** **DATE**

Explore the "Using Diasday Gel" section at the link below for resources to assist your patients: www.diasdaygel.com