

Patient Information Form

Please fax completed Form to:

Phone: 800-444-DRUG (800-444-3784)

Last Name _____ First _____ Middle Initial _____ Social Security Number _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____ Home Telephone _____

Primary Insurance

Prescription Drug Insurance

Company Name _____

Telephone _____

Subscriber Name _____

Relation to Patient _____

Social Security _____ Date of Birth _____ Date of Birth _____

Policy ID _____ Group _____ Group _____

Employer _____

Copy of prescription drug card attached

I authorize the COLAZAL® Reimbursement HELpline to have access to all medical and insurance coverage information and records which pertain to the patient listed on this form, necessary to verify and/or obtain insurance coverage for COLAZAL®. I further understand that all information and documentation will be held in strict confidence by the COLAZAL® Reimbursement HELpline and will not be shared with any third party except in summary format, after verification of coverage.

Signature of patient _____

Date _____

Patient Medical Information

Primary diagnosis : _____ **ICD-9 code :** _____

Previous treatment(s)

(specify) _____

Justification for COLAZAL® treatment (check all that apply)

intolerant of (specify treatment) _____ insufficiently responsive to (specify treatment) _____

Other (please specify) _____

Regimen 750mg capsule(s) _____ **Length of treatment:** _____

Physician Information

Practice Name: _____ **Tax ID#:** _____

Address: _____ **Fax #:** _____

Physician Signature _____ Date _____

Physician Name (Please Print) _____ Telephone # _____