YcanthRx™ Patient Enrollment Form

[*required fields]

Physician Information

*Prescriber Name: Specialty:

*Address

*City/State/Zip:

*Practice Name: Office Contact:

*NPI#: *State Med Lic#: *Tax ID#:

*Phone: *Fax:

Email:

Patient Information

*Patient Name: DOB: / /

Male ☐ Female ☐ Other ☐ Preferred Language: English ☐ Spanish ☐ Other ☐

*Address:

City/State/Zip:

*Home Phone: *Cell Phone:

Email:

*Parent/ guardian responsible for child's insurance coverage: Relationship to Patient:

*Contact Phone:

Insurance Information

☐ Patient has no insurance coverage. **Please include a copy of front and back of patient's insurance card(s).**

*Primary Insurance: *Policy ID#: *Group#:

Subscriber's Name (if not self): DOB: / /

Relationship to Patient: Employer:

Secondary Insurance: Policy ID# Group#:

Subscriber's Name (if not self): DOB: / /

Relationship to Patient: Employer:

Pharmacy Benefit: Yes No Carrier:

Clinical Information

Sample Product Administered? Yes No

*ICD-10 Code: B08.1 Other:

*CPT Code Description: *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions*

CPT 17110 (Up to 14 lesions) CPT 17111 (15 or more lesions)

Prescription Information

* Rx: YCANTH (cantharidin) topical solution 0.7% for the FDA-approved treatment of molluscum contagiosum

Quantity: Refill: Times: Days' Supply:

Directions:

NDC/ Package Size: ☐ 1- count (NDC: 71349-0070-01) ☐ 6- count (NDC: 71349-0070-06)

By signing below, I certify that (a) the above-prescribed therapy for molluscum contagiosum is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed therapy(ies), to manufacturer and its agents or contractors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.

***Prescriber's Signature** NO STAMPS PLEASE:

Date:

YcanthRx™

Monday-Friday
(8am- 8pm ET)

Phone:
1-855-YCANTHS
(1-855-922-6847)

Fax:
1-844-YCANTHS
(1-844-922-6847)

Please see Important Safety Information and full Prescribing Information at YCANTHPro.com

Patent: www.verrica.com/patents

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