Waylis Access & Affordability Program

ProModRx

Phone: (888) 218-8897 • Fax: (844) 470-1931

Prescription Information and Enrollment Form

Please fax completed form to the Waylis Program: (844) 470-1931.

PATIENT INFORMATION (REQUIRED)			
First Name:	Last Name:	Date of Birth: Gender: ☐Female ☐Male	
Cell Phone:	Home Phone:	Email:	
Preferred Method of Contact: ☐ Phone Call ☐ Text ☐ Email			
Address:	City:	State:	Zip:

PRESCRIBER INFORMATION (REQUIRED)			
First Name:	Last Name:	NPI:	
Phone:	Fax:	Email:	
Address:	City:	State:	Zip:
Prior Auth Coordinator:	Email:		
Phone:	Ext:	Fax:	

PATIENT DIAGNOSIS (REQUIRED)	
ICD-10 Code:	Allergies:
Diagnosis:	
Height (cm/in):	Weight (kg/lb):
New to Therapy: ☐ Yes ☐ No, Start Date of Current Therapy: _____	

CURRENT MEDICATIONS (REQUIRED)		
Drug Name	**Drug Name**	**Drug Name**
•	•	•
•	•	•
•	•	•
•	•	•

PRESCRIPTION INFORMATION (REQUIRED)		
☐ **COREG CR 10mg Capsules** ☐ **COREG CR 20mg Capsules**	☐ **COREG CR 40mg Capsules**	☐ **COREG CR 80mg Capsules**
Quantity:	Day Supply:	Refills:
Directions:		
Prescriber Signature:		**Date:**
Brand Medically Necessary (**Must Handwrite**):		