

PRODUCT PRESCRIPTION FORM

Physician Instructions: Please complete and sign the form. Fax or mail the completed form to the address below:

ENcourage Foundation®
 PO BOX 4133
 Gaithersburg, MD 20885-9901
 Phone: 800/282-7752 Fax: 888/508-8083

Physician Information

Physician First Name:		Physician Last Name:	
Facility/Practice Name:		Facility/Practice Contact Name: (other than physician)	
Address: (PO Box is not accepted)			
City:	State:	Zip Code:	
Phone #:	State License #:	Email:	

Patient Information

Patient First Name:		Patient Last Name:	
Date of Birth:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

Prescribing Information for Enbrel® (etanercept)

Medication	Dose	Frequency	Check One	Shipping Schedule
ENBREL	50mg SureClick®	Once weekly	<input type="checkbox"/>	<u>New Enrollees/Step-down Dosing:</u> <ul style="list-style-type: none"> One year supply from prescription written date. Shipment monthly for the first three months, then every three months for the remaining nine months. <u>Re-enrollees:</u> <ul style="list-style-type: none"> One year supply from prescription written date. Four shipments of three months supply each.
		Twice weekly for 3 months; then once weekly (Step-down Dosing)	<input type="checkbox"/>	
ENBREL	50mg Prefilled Syringe	Once weekly	<input type="checkbox"/>	
		Twice weekly for 3 months; then once weekly (Step-down Dosing)	<input type="checkbox"/>	
ENBREL	25mg Vial	Once weekly	<input type="checkbox"/>	
		Twice weekly	<input type="checkbox"/>	
ENBREL	25mg Prefilled Syringe	Once weekly	<input type="checkbox"/>	
		Twice weekly	<input type="checkbox"/>	
ENBREL			<input type="checkbox"/>	

All product shipments are sent to the patient. If you would like to have product shipped to the Physician's office instead, please check here .
 Prescription length is 12 months unless otherwise noted here: _____

I have prescribed ENBREL for the above patient. My patient gave consent for me to provide this information. I understand that no third party or patient should be billed or charged for ENBREL provided by this program. I understand that no free product should be sold, traded, or distributed for sale.

X _____
 Physician's Original Signature (stamps not accepted) Date

Completion of this form is independent of the application process and does not guarantee enrollment in the ENcourage Foundation®. The ENcourage Foundation® must review the complete application and supporting documentation to determine the patient's eligibility.

For Internal Use Only

Case # :	Patient ID# :
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