



**PLO Gel Enrollment Form**  
**Phone: 866.474.8326 ▪ Fax: 877.305.6745**

Last Name		First Name		Today's Date		Date Needed	
Home Phone Number ( )		Work Phone Number ( )		Prescriber		Hospital/Clinic	
Home Address		City	State	Zip	Address		City State Zip
Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home <input type="checkbox"/> Other				Phone Number ( )		Fax Number ( )	
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other				Office Contact		Special Instructions	
Social Security Number		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth		Preference: <input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> Email Email		

**INSURANCE INFORMATION**  
**(fill out entirely or fax a copy of patient's insurance card, both sides)**

Primary Insurance: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Rx Drug Card #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Rx Drug Card #: \_\_\_\_\_

**PATIENT HISTORY**

Patient Allergies (Please review that patient is not allergic to any components of prescription formulation):  NKA  
 \_\_\_\_\_  
 \_\_\_\_\_

Is this patient enrolled in a Remodulin® study?  
 No  Yes Study #: \_\_\_\_\_

**COMPLETE THE FOLLOWING:**

**FORMULATION A in PLO Gel**  
 Ketoprofen 10%  
 Lidocaine USP 5%  
 Neurontin 6%  
 Transdermal (PLO) Gel

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**FORMULATION B in PLO Gel**  
 Ketoprofen 10%  
 Lidocaine USP 5%  
 Neurontin 6%  
 Ketamine 5%  
 Transdermal (PLO) Gel

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**FORMULATION C in PLO Gel**  
 Ketoprofen 10%  
 Lidocaine USP 5%  
 Neurontin 6%  
 Ketamine 5%  
 Amitriptyline 2%  
 Transdermal (PLO) Gel

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**FORMULATION D in PLO Gel**  
 Ketoprofen 10%  
 Lidocaine USP 5%  
 Neurontin 6%  
 Ketamine 5%  
 Amitriptyline 2%  
 Clonidine 0.29%  
 Transdermal (PLO) Gel

Push-Up Vials:  
 30ml  50ml  100ml

Sig: Apply to old sites up to 4 times per day as needed for pain.

Refill x \_\_\_\_\_ month(s)

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space.

**Please complete and fax to 877.305.6745. CuraScript IP will contact patient to arrange for delivery of medication, billing and to give complete instructions to patient on correct use of medication. Please call 866.4PH.TEAM (866.474.8326) with any questions.**

**PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS**

Physicians Signature: \_\_\_\_\_ UPIN/DEA #: \_\_\_\_\_ State License#: \_\_\_\_\_