

PRODUCT PRESCRIPTION FORM

Patient	Patient Name: _____ <small>LAST FIRST</small>		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: / /			
	First Name: _____		Last Name: _____	State License #: _____			
Physician	Phone #: () -		Fax #: () -				
	Street Address: _____ <small>Street (PO BOX not accepted) City State Zip</small>						
	Facility/Practice Name: _____		Facility/Practice Contact Name: (other than physician)				
PRESCRIPTION	MEDICATION / DOSE		FREQUENCY		QUANTITY	REFILLS	
	Enbrel[®] (etanercept):						
	<input type="checkbox"/> 50mg SureClick [®]		<input type="checkbox"/> Once weekly <input type="checkbox"/> Twice weekly for 3 months; then once weekly (Step-down Dosing)		_____	_____	<input type="checkbox"/> 1 year or <input type="checkbox"/> x _____
	<input type="checkbox"/> 50mg Prefilled Syringe		<input type="checkbox"/> Once weekly <input type="checkbox"/> Twice weekly for 3 months; then once weekly (Step-down Dosing)		_____	_____	<input type="checkbox"/> 1 year or <input type="checkbox"/> x _____
	<input type="checkbox"/> 25mg Vial		<input type="checkbox"/> Once weekly <input type="checkbox"/> Twice weekly		_____	_____	<input type="checkbox"/> 1 year or <input type="checkbox"/> x _____
	<input type="checkbox"/> 25mg Prefilled Syringe		<input type="checkbox"/> Once weekly <input type="checkbox"/> Twice weekly		_____	_____	<input type="checkbox"/> 1 year or <input type="checkbox"/> x _____
	<input type="checkbox"/> _____		<input type="checkbox"/> _____		_____	_____	<input type="checkbox"/> 1 year or <input type="checkbox"/> x _____
	Prescription length is 12 months unless otherwise noted here:						
New Enrollees/Step-down Dosing: Shipped monthly for the first 3 months, then every 3 months for the remaining number of refills.			Re-enrollees: 4 shipments of 3 months' supply each on a 1 year refill prescription.				
SHIPMENT INSTRUCTIONS: ENBREL is shipped to the patient directly. If you prefer to have the product shipped to the Physician's office instead, please check here: <input type="checkbox"/> Ship to Physician's Office							

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.

Physician's Original Signature (stamps not accepted)

Date Signed

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 to determine the patient's eligibility.