Patient Enrollment Form For the On-Label Use of YCANTH

[*required fields]

Physician Information

*Prescriber Name: Specialty:

Practice Name: Office Contact:

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

*Address:

*City/State/Zip:

*Phone: *Fax:

Email:

Patient Information

*Patient Name:

☐ Male ☐ Female *DOB: / / 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: *Policy ID#: *Group#:

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

Relationship to Patient: Employer:

Secondary: Policy ID# Group#:

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

Relationship to Patient: Employer:

Pharmacy Benefit: ☐ Yes ☐ No Carrier:

Policy/Group#: Member ID:

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:

☐ Dispense as Written ☐ Substitutions Allowed

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:

Y-Access SUPPORT SOLUTIONS

Monday–Friday
(8 AM–5 PM ET)

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

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

Ycanth (cantharidin) TOPICAL SOLUTION 0.7%

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

(04/24) US-YCN-00003P