SYNERA®
(lidocaine and tetracaine) Topical Patch

SNAP…The SYNERA NOW Access Program

PHARMACY ORDER FAX

PATIENT ENROLLMENT INFORMATION

SNAP is a valuable patient support service brought to you by Galen US Inc, makers of SYNERA. There is no additional cost to you for this service. You pay only what you would pay at your local pharmacy.

NAME: _____

ADDRESS: _____
(Please include street number, name and apt. number, if applicable. No P.O. boxes please)

CITY_____ STATE _____ ZIP_____

LAST FOUR DIGITS OF SS #: _____ DATE OF BIRTH _____ _____ _____

DAYTIME PHONE #: _____ _____ _____
(Preferred contact number of patient or someone we can contact about the prescription)

E-MAIL: _____

SHIPPING ADDRESS: _____
(If different from mailing address. No P.O. boxes please)

CITY_____ STATE _____ ZIP_____

PRESCRIPTION INSURANCE INFORMATION

(COPY OF FRONT/BACK OF INSURANCE CARD IS ACCEPTABLE)

NAME OF PRIMARY INSURANCE PLAN _____

GROUP# _____ BIN# _____ PCN# _____

NAME OF PRIMARY MEMBER: _____ ID# _____

PATIENT ENROLLMENT AUTHORIZATION

I hereby authorize any insurer, public or private, hospital, physician or other healthcare provider to disclose to Transition Patient Services and its agents all medical information, financial and insurance information and other personal identifying information for the purpose of my participation in the pharmacy delivery service. I also authorize Transition Patient Services and its agents to disclose all such information to any person or entity listed above for the purpose of my participation in this program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I authorize Transition Patient Services to use my Social Security number for identification purposes and record keeping only. I verify that all information provided herein is complete and accurate. I have read, understand, and agree to all of the above.

_____ _____
Patient Signature Date

PRESCRIBER INFORMATION

NAME: _____

DEA #: _____ **NPI #:** _____

ADDRESS: _____

CITY_____ **STATE** _____ **ZIP**_____

PHONE #: _____ **FAX #:** _____

OFFICE CONTACT: _____

PHYSICIAN EMAIL: _____

PRESCRIPTION INFORMATION

ALLERGIES: _____ **DATE:** _____

_____

_____

DRUG/DOSE	INSTRUCTIONS	QTY	REFILLS
SYNERA, Box of 10	Up to ____ patches per week		

_____
Dispense As Written

FAX COMPLETED FORM TO *SNAP CUSTOMER SERVICE* AT:
FAX #: (866) 694-2555

For SNAP Customer Service call 1-844-GALENRX (1-844-425-3679)

GALEN
Advancing Human Health

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