Patient Enrollment Form

Please complete and fax this form to EAGLE CAN at 1-833-324-5346.
Both you and your patient must sign on page 2.
For assistance or additional information, call EAGLE CAN at 1-833-324-5322.

EAGLE CAN™
Care & Access Network

By submitting this form, I am requesting support services on behalf of the patient indicated below. Services include benefits verification and prior authorization support.

REQUIRED FIELD*

PATIENT INFORMATION

First Name*	Middle Initial	Last Name*	
DOB (MM/DD/YYYY)*	Gender	Email	
Address*	City*	State*	Zip*
Primary Phone Number*	Secondary Phone Number		
Okay to Contact Patient for Additional Information?	U.S. Residency Status		
Alternate Contact Name	Relationship	Phone Number	

INSURANCE INFORMATION

Check if patient does not have insurance	Check if patient has secondary insurance
Primary Insurance Name*	Insurance Phone*
Policy #*	Group #*
Policyholder Name*	Relationship to Patient
Secondary Insurance Name*	Insurance Phone*
Policy #*	Group #*
Policyholder Name*	Relationship to Patient

PRESCRIBER INFORMATION

First Name*	Middle Initial	Last Name*	
Tax ID #	NPI #*	Group NPI #	
Payer Specific Provider #			
Practice Name*			
Address*	City*	State*	Zip*
Practice Phone Number*	Practice Fax Number*	Practice Email	
Practice Contact Name*			

© 2022 Eagle Pharmaceuticals, Inc.
ALL RIGHTS RESERVED
MLR-NON-US-0123

Patient Enrollment Form

Please complete and fax this form to EAGLE CAN at 1-833-324-5346.
Both you and your patient must sign on page 2.
For assistance or additional information, call EAGLE CAN at 1-833-324-5322.

EAGLE CAN™
Care & Access Network

CLINICAL INFORMATION

Primary Diagnosis*	Secondary Diagnosis	Tertiary Diagnosis

Eagle Product Prescribed*

☐ BELRAPZO® (bendamustine hydrochloride injection) ☐ PEMFEXY™ (pemetrexed injection)

Product NDC:

Previous Therapies, if any

Concurrent Therapies, if any

Site of Care*

ATTESTATIONS AND SIGNATURES

Prescriber Attestation: I confirm that I have prescribed the Eagle product identified above as an appropriate treatment for this Patient. I have not been offered or promised anything of value by Eagle in exchange for writing this prescription. I confirm that the above provided information is true and correct to the best of my knowledge.

Prescriber Signature*	Date*

Patient Attestation: I confirm that the above provided information is true and correct to the best of my knowledge and I request the support provided by the EAGLE CAN program as described above. I understand I may revoke this request at any time by phoning the EAGLE CAN program at 1-833-324-5322.

Patient Signature*	Date*

© 2022 Eagle Pharmaceuticals, Inc.
ALL RIGHTS RESERVED
MLR-NON-US-0123