

# PANCRECARB®

(pancrelipase)

Delayed-Release Capsules – Bicarbonate-Buffered and Enteric-Coated Microspheres



## FIRST START Program<sup>SM</sup>

Digestive Care, Inc. provides all institutions with the ability to offer an initial supply of PANCRECARB® (pancrelipase) "Free of Charge" to your patients thru the First Start Program<sup>SM</sup>. A First Start supply will be sent directly to your patient.

Please check one:

Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Month Day Year

PANCRECARB® MS-8 NDC 59767--001-01 Bottle containing 100 Capsules

PANCRECARB® MS-16 NDC 59767--003-01 Bottle containing 100 Capsules

Dispense \_\_\_\_\_ Qty

Fax this First Start Form to Freedom Pharmacy at: **Fax 866-482-6158**

Florida Residents Please Fax to: 407-898-2903 • Long Distance: 866-482-6158

### Physician Information:

Physician Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Sig: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ DEA#: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic Address: \_\_\_\_\_ Fax: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Patient Information:

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Street Address: \_\_\_\_\_ (Do not use P.O. Box Number)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Consent and Authorization Agreement

I hereby authorize Freedom Pharmacy to enroll the above-named patient in the PANCRECARB® First Start Program<sup>SM</sup>, sponsored by Digestive Care, Inc. (DCI). I understand that enrollment in this program enables the patient to receive an initial free supply of PANCRECARB® product. PANCRECARB® will be provided by Freedom Pharmacy. I understand that Freedom Pharmacy may use the health information I provide for internal educational and/or marketing purposes and will only disclose certain health information to DCI as required by law to report any adverse drug events. Both Freedom Pharmacy and DCI will maintain the confidentiality of patient information. Contact Freedom Pharmacy at 1 800 741-4427 for questions. DCI reserves the right to withdraw or cancel this offer at any time without notice. I understand that the PANCRECARB® First Start Program<sup>SM</sup> is subject to the availability of products and does not constitute an entitlement.

Patient Name (please print): \_\_\_\_\_ Patient Signature: \_\_\_\_\_

IF PATIENT IS A MINOR: Parent/Guardian/Guarantor Name (please print): \_\_\_\_\_

Patient/Guardian/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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