

# General Enrollment Form

(Please use black ink)



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Phone # (866-458-9246)

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## PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
Address 2 \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Gender \_\_\_\_\_  
Language Preference:  English  Spanish  Other \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Group/Hospital \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION (Fill out entirely or fax a copy of patient's insurance card including both sides)

Prescription Card: Name of Insurer \_\_\_\_\_ ID # \_\_\_\_\_ BIN \_\_\_\_\_ PCN \_\_\_\_\_ Group \_\_\_\_\_  
Primary Insurance: Subscriber \_\_\_\_\_ ID # \_\_\_\_\_ Name of Insurer \_\_\_\_\_ Group \_\_\_\_\_  
Secondary Insurance: Subscriber \_\_\_\_\_ ID # \_\_\_\_\_ Name of Insurer \_\_\_\_\_ Group \_\_\_\_\_

## MEDICAL INFORMATION (Attach separate sheet if needed)

Diagnosis – Please include diagnosis name with ICD-10 code

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Date of Diagnosis \_\_\_\_\_

Additional Information Therapy  New  Reauthorization  Restart

Weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ cm/in  
Allergies \_\_\_\_\_  
Lab Data \_\_\_\_\_  
Concomitant Medications \_\_\_\_\_  
Additional Comments \_\_\_\_\_

## Injection Training/Home Health Coordination:

Injection training/home health will be /has been conducted by the physician's office:  Yes  No If Yes, Date \_\_\_\_\_  
Specialty pharmacy to coordinate injection training/home health nursing:  Yes  No Agency of Choice \_\_\_\_\_

## PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in th patient's insurer's provider network.

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_  
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

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