

VITAL INFORMATION

Enrollment Form
Phone: (877)229-1724 | Fax: (877)229-1725

PATIENT INFORMATION

(Complete the following or **send patient demographic sheet.**)

Please fax copy of patient's insurance card including both sides

Name: _____
 DOB: _____ Gender: M / F Height: _____ Wt: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Alternate Phone: _____
 Last 4 digits SS#: _____ Email: _____
 Emergency Contact: _____
 Relationship: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 State Lic. #: _____ NPI: _____
 Facility Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 Contact: _____
 Phone: _____ Email: _____

Please Send all Clinical Notes, Test and Lab Results to Help Facilitate Prior Authorization Processing

ICD-10 Code: _____ Primary Diagnosis: _____ BSA: _____
 Other Diagnosis: _____
 Allergies: _____
 Therapy: New Restart Prior Therapies: _____

PRESCRIPTION INFORMATION

| <u>Medication</u> | <u>Dose</u> | <u>Directions</u> | <u>Quantity</u> | <u>Refills</u> |
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Deliver To: Home Physician * If shipped to physician's office, physician accepts on behalf of patient for administration on office

Prescriber Signature _____ Date _____ Brand Name Required Yes

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 and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment 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 this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.