PRESCRIPTION & ENROLLMENT FORM

☐ New patient
☐ Current

1 PATIENT INFORMATION

Patient name _____

Date of birth _____ ☐ Male ☐ Female Last 4 digits of SSN _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____ Work phone _____

Cell phone _____ Evening phone _____

E-mail address _____

Insurance company name _____

Insurance company phone # _____

Insured name _____

Insured employer _____

Relationship to patient _____

Prescription card ☐ No ☐ Yes If yes, carrier _____

Policy # _____ Group # _____

Is patient eligible for Medicare? ☐ No ☐ Yes

Please attach front and back copy of patient's insurance cards, if available.

2 PRESCRIBER INFORMATION

Prescriber name _____

Office contact _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

DEA # _____

Physician Medicaid UPIN # _____

MD specialty _____

To reach your team, call toll-free 1 888 608-9010.

Please fax completed form to your drug therapy team 1 888 302-1028.

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3 CLINICAL INFORMATION

Primary ICD-9 code _____

4 PRESCRIBING INFORMATION

Deliver product to: ☐ Office ☐ Patient home ☐ Clinic /clinic location

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

Prescriber printed name _____

Prescriber signature (sign below) **Date** _____

_____ _____

Dispense as written **Substitution allowed**

(Physician attests this is his/her legal signature. **NO STAMPS)**

This prescription is valid only if transmitted by means of a facsimile machine.