General Enrollment Form

Fax: (215) 471-4001
Phone: (215) 471-4000

PATIENT INFORMATION:

Patient's Name: ______________________________________
Address: ____
City, State, Zip Code: __________________________________
Home Phone: ________________________
Alternate Phone: _____________________
DOB: _______________
Last 4 Digits of SS#: _______________
Gender: _______________
Language Preference: ___________________

PRESCRIBER INFORMATION:

Prescriber's Name: ____
DEA: _______________________
NPI: ________________________
Address: ____
City, State, Zip Code: ____
Phone: ______________________
Fax: _______________________
Contact Person: ____
Contact Person's Phone: _______________________

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

Prior Authorization Reference #: _________________

MEDICAL INFORMATION: (may attach separate sheet if needed)

Diagnosis: Please include diagnosis **and** ICD-10 code

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Additional information:

Weight: __________ kg/lb Height __________ cm/in
Allergies: ____
Lab Data: ____
Concomitant Medications: ______________________________________
____
Injection Training Required: ☐ Yes ☐ No
Therapy: ☐ New ☐ Reauthorization ☐ Restart
Start Date ____________ Review Date _____________

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills

Please deliver to: ☐ Patient ☐ Office ☐ Other ____________ by this date: ____________

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 the patient's insurer's provider network.

☐ Product Substitution Permitted ☐ Dispense as Written

Prescriber's Signature: ___________________________________

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