



Fax Referral To: 800-323-2445  
Phone: 866-278-5108

# Specialty Pharmacy Enrollment Form



## 6 Simple steps to submitting a referral

Ship To: Self-administered drugs will be shipped to the patient. Provider-administered drugs:  Patient  Office  Other: \_\_\_\_\_

### 1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_  Home  Cell  Work  
Alternate Phone: \_\_\_\_\_  Home  Cell  Work  
DOB: \_\_\_\_\_ Gender:  Male  Female  
E-mail: \_\_\_\_\_  
Last Four of SS #: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### 2 PRESCRIPTION INFORMATION

Prescriber's Name: \_\_\_\_\_  
State License #: \_\_\_\_\_ NPI # \_\_\_\_\_  
DEA #: \_\_\_\_\_  
Group or Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

### 3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form if available (front and back)

### 4 DIAGNOSIS AND CLINICAL INFORMATION

<b>Diagnosis (ICD-9 or ICD-10):</b>		<b>Additional Clinical Information:</b>	
Please include diagnosis name and code:		Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart	
ICD9 or ICD10	Description	Height: _____	in/cm
_____	_____	Weight: _____	kg/lbs
_____	_____	Allergies: _____	
_____	_____	Concomitant Medications: _____	
_____	_____	Additional Comments: _____	
		Has patient received injection training? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

### 5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

**6** X \_\_\_\_\_ **PHYSICIAN SIGNATURE REQUIRED** \_\_\_\_\_ X \_\_\_\_\_  
DISPENSE AS WRITTEN (Date) PRODUCT SUBSTITUTION PERMITTED (Date)

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