



Patient Enrollment Form

1. DOCTOR/PRESCRIBER FILL OUT AND FAX TO: 1-888-773-7386 or Call: 1-888-773-7376

- Faxes will only be accepted from a doctor's office. Class II medications cannot be faxed.

Patient Information

Name: Phone #1: Phone #2: Address: Allergies: No Known Allergies City: ST: Zip: Health Conditions: Date of Birth: Expected Start Date:

Statement of Medical Necessity

Patient Weight: lbs kg Primary Diagnosis: ICD9 Code:

Drug Delivery Information If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

In Office Delivery Home Delivery for Self Injection/Administration Contact: Home Delivery for Home Health Administration Phone #: Other: Address:

Insurance Information Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: Secondary: Insured: Insured: ID #: Group #: ID #: Group #: Phone #: Rx Drug Card #: Phone #: Rx Drug Card #: Rx Bin #: Rx PCN #: Rx Grp #: Rx Bin #: Rx PCN #: Rx Grp #:

Doctor/Prescriber Information NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: Office Contact: Address: NPI #: DEA #: City: ST: Zip: Phone #: Fax #:

2. COMPLETE THE FOLLOWING Rx FORM -OR- TAPE Rx HERE

Rx form table with columns: Drug Name/Form/Strength, Quantity, Directions for Use, Refills. Includes sections for Needles, Syringes, and signatures.