

# 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.