SPECIALTY PHARMACY™
Enrollment Form

Pharmacy Phone: _____

Fax completed forms and prescriptions to _____ or electronically prescribe to Target Pharmacy #XXXX

Date Needed: _____ Preferred Pharmacy Pickup Location: _____

Patient Information

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Email address: _____

Insurance Provider (Please include a copy of front and back of card): _____

ID #: _____ Policy/Group #: _____ Phone #: _____

Name of Insured: _____ Relationship to Insured: _____ Employer: _____

Prescription Card: ☐ Yes ☐ No Carrier: _____ Policy/Group #: _____

Clinical Assessment

Primary ICD-9 Code and Condition: _____ Allergies: _____

☐ Patient is new to therapy ☐ Patient is restarting therapy

☐ Patient is currently on therapy* (Start Date: _____) _____

_____

Current Weight: _____ (kg/lbs) Current Height: _____ (cm/in) *Please attach a current medication list.

Prescription Information

Medication	Dose	Directions/Frequency	Quantity	Refills

Prescriber Information

Prescriber's Name: _____ Practice/Facility Name: _____

Prescriber NPI/DEA #: _____ Contact: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ Best Time to Call: _____

Prescriber's Signature: _____ Date: _____

Pharmacy can accept only original hardcopy prescription drug orders from patients. Faxed prescriptions must be sent directly from prescribing practitioners.

SXX