elixir
SPECIALTY PHARMACY

Specialty Pharmacy Prescription and Enrollment Form
Phone: (877) 437-9012 Fax: (877) 309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: _____

Date of Birth: _____ Gender: ☐ Male or ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Please attach copy of front and back of patient's prescription ins. card(s) if applicable

Insurance Company Name: _____

Insurance Company Phone: _____

Policy holder: _____

Policy holder Employer: _____

Relationship to Patient: _____

ID# _____ Group# _____

RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/Organization Name: _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

DEA# _____ NPI# _____

License#: _____ Medicaid UPIN#: _____

Physician Specialty: _____

Clinical Information and Prescription

Primary Diagnosis: ICD-10 Code: _____

Description: _____

Date of Diagnosis or Years with Disease: _____

Patients Allergies: _____

_____

Latex allergy: ☐ Yes ☐ No

Patient Weight: _____ Patient Height: _____ Date: ____/____/____

℞

Refills Authorized: ☐ 0 ☐ 1 ☐ 3 ☐ 6 ☐ 11 ☐ Other: _____

Date Shipment Needed: _____ **Ship to:** ☐ **Patient** ☐ **Prescriber** ☐ **Clinic**

Shipment Address: _____ Attn: _____

City: _____ State: _____ Zip: _____

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

X_____ **Date:** _____/_____/_____

Physician Signature (no stamps)

If physician requests Brand Name only,
DAW MUST be HANDWRITTEN in the following space provided:

Updated September 2023