elixir SPECIALTY PHARMACY

Specialty Prescription and Enrollment Form

Phone: (877) 437-9012 Fax: (877) 309-0687

☐ New to Therapy
☐ Current Therapy

Customer Information

Customer 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 customer's prescription insurance card(s), if applicable.
Insurance Company Name: ______________________________
Insurance Company Phone: ______________________________
Policy holder: ______________________________
Policy holder Employer: ______________________________
Relationship to Customer: ______________________________
ID# ______________ Group# ______________
RxBIN: ____________ RxPCN: ______________

Prescriber Information

Practice/Organization Name: ______________________________
Physician Name: ______________________________
Address: ______________________________
City: ______________ State: __________ Zip: ________
Phone#: ______________ Fax#: ______________
DEA# ______________ NPI# ______________
License#: ____________ Medicaid UPIN#: ____________
Physician Specialty: ______________________________

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Clinical Information and Prescription

Primary Diagnosis: ICD-10 Code: __________
Description: ______________________________
Date of Diagnosis or Years with Disease: ______________________________
Patient's Allergies: ______________________________
____
Latex allergy: ___yes ___no
Patient Weight: __________ Patient Height: ____________ Date: __________

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 ______________________________

Physician Signature (no stamps) **Date**

If physician requests brand name only, "DAW" <u>MUST BE HANDWRITTEN</u> in the following space provided: ☐