

Phone: 855-553-3568
Fax: 844-272-1501

Proprium Pharmacy

General Enrollment Form

Ship to: Patient Office Other:

Date:

Needs by Date:

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____
Address _____
Address 2 _____
City, State, ZIP _____
Home Phone _____
Alternate Phone _____
DOB _____ Last Four of SS# _____ Gender _____

PRESCRIBER INFORMATION

Prescriber's Name _____
State License # _____ UPIN _____
DEA _____ NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____
Contact Person _____ Phone _____

INSURANCE INFORMATION *(Fill out entirely or fax a copy of patient's insurance card including both sides)*

Prescription Card: Name of insurer _____ ID# _____ BIN _____ PCN _____ Group _____
Primary Insurance: Subscriber _____ ID# _____ Name of Insurer _____ Phone _____
Secondary insurance: Subscriber _____ ID# _____ Name of Insurer _____ Phone _____

MEDICAL INFORMATION *(Attach separate sheet if needed)*

Diagnosis	Additional Information	Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart
<i>Please include diagnosis and ICD-10</i>	Weight _____ kg/lb Height _____ cm/in	
	Allergies _____	
	Lab Data _____	
	Concomitant Medications _____	
	Additional Comments _____	
Date of Diagnosis _____		

Injection Training/Home Health Coordination:

Injection training/home health will be/has been conducted by the physician's office: Yes No If yes, Date _____
Specialty pharmacy to coordinate injection training/home health nursing: Yes No Agency of Choice _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills

By signing below, I authorize Proprium RX and it's representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber's Signature _____

PRODUCT SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN

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