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

Proprium Pharmacy

General Enrollment Form

Ship to: ☐ Patient ☐ Office ☐ Other: Date: Needs by Date:

PATIENT INFORMATION	PRESCRIBER INFORMATION
Please complete the following or send patient demographic sheet	Prescriber's Name _____
Patient Name _____	State License # _____ UPIN _____
Address _____	DEA _____ NPI _____
Address 2 _____	Group/Hospital _____
City, State, ZIP _____	Address _____
Home Phone _____	City, State, ZIP _____
Alternate Phone _____	Phone _____
DOB_____ Last Four of SS#_____ Gender____	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: ☐ New ☐ Reauthorization ☐ Restart
Please include diagnosis and ICD-10	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