Specialty Pharmacy Enrollment Form

Please complete the following information.

Patient Information	Last Name:	First Name:	MI:
	Street Address:		
	City:	State:	Zip:
	DOB:	Sex: ☐ Male ☐ Female	
	Home phone:	Cell:	Work:
Alternate Shipping Address	Street Address:		
	City:	State:	Zip:
Insurance Information	Prescription Benefit Plan:		
	Patient ID#:	Group/Policy #:	
	Subscriber Name (if not patient):		
	Insurance Company Phone #:		
	Medical Plan Name:		
	Medical Plan ID#:	BIN #:	
Patient Health Information	Height:	Weight:	Diabetic: ☐ Yes ☐ No | Insulin Dependent: ☐ Yes ☐ No
	Primary diagnosis/ICD-10 requiring specialty medication(s):		
	Name of specialty medication:		
	Additional medical condition(s):		
	Drug allergies:		
	List all prescription, over the counter and herbal medications taken regularly: (use additional sheet if necessary)		
Practitioner Information	Last Name:	First Name:	
	Office Contact:	License #:	
	NPI #:	DEA #:	
	Street Address:		
	City:	State:	Zip:
	Phone Number:	Fax Number	

Generic equivalents are usually less expensive than brand name drugs. If we dispense a brand name drug, you may be responsible for a higher copayment and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box.

___ **I do not accept a generic equivalent.**