elixir
SPECIALTY PHARMACY

IV Chemotherapy Enrollment Form

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

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: _____
Date of Birth: _____ Sex: M or F Caregiver:_____
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:_____
Copay Card: _____

Prescriber Information

Practice/ Organization Name: _____
Prescriber Name:_____
Address:_____
City: _____State: _____ Zip: _____
Phone#:_____Fax#:_____
DEA#:_____NPI#:_____
License#:_____Medicaid UPIN#:_____
Physician Specialty: _____
Prior Authorization Information: ☐ Please fax PA forms ☐ PA has been started ☐ PA has been approved, auth #: _____ ☐ Other: _____
Date Shipment Needed: _____
Ship to: ☐ Clinic/Hospital ☐ Prescriber (Cannot ship to patient)
Shipment Address: _____Attn: _____
City: _____State: _____ Zip:_____
If shipped to the prescriber's office, prescriber accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Primary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Secondary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Height: _____inches/cm Weight: _____lb/kg BMI:_____ Date of Measurement: ___/_____/_____
Chemo Cycle: How many days: _____ How many weeks of therapy: _____
Allergies: _____
Current Medications: _____
If applicable:
Where is drug being administered? ☐ Clinic ☐ Hospital
Facility Name / Phone: _____
Does the administering facility have access to a chemotherapy hood for proper drug preparation? ☐Yes ☐No
Is the administering facility capable of mixing/have necessary supplies? ☐ Yes ☐ No

Drug	Strength	Dose	Frequency	Refills

Prescriber Signature: *X*_____ Date: _____/_____/_____

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