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: _____

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"
MUST BE HANDWRITTEN in the following space provided: