Proprium PHARMACY

GENERAL ENROLLMENT FORM

Fax Referral To: 757-819-7827
Phone: 855-553-3568

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ **Alternate Phone:** _____

Email: _____ **Gender:** ☐ **M** ☐ **F**

DOB: _____ **Last Four of SSN:** _____

Preferred Language: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

DEA #: _____ **NPI #:** _____

Group or Hospital: _____

Address: _____

City, State, Zip: _____

Phone #: _____ **Fax #:** _____

Contact Person: _____ **Contact's Phone:** _____

INSURANCE INFORMATION (*Please FAX copy of prescription and insurance cards (front and back) with this form, if available)*

Primary Insurance: Name of insurer _____ ID # _____ BIN _____ PCN _____ Group _____

Secondary Insurance: Name of insurer _____ ID # _____ BIN _____ PCN _____ Group _____

DIAGNOSIS AND CLINICAL INFORMATION *(Please FAX recent labs and clinical notes with prescription to expedite Prior Authorization)*

Diagnosis Description **ICD-10 Code**

_____

_____

Date of Diagnosis: _____

Injection training provided by:

☐ **Doctor office** ☐ **Pharmacy** ☐ **Other:** _____

Needs By Date: _____

☐ **New Therapy** ☐ **Reauthorization** ☐ **Restart**

Current Therapy: _____

Will the patient be stopping the above medication before starting new therapy?

☐ **Yes Discontinuation Date**: _____
☐ **No**

Has the patient failed other therapies in the past? ☐ **Yes** ☐ **No**

If so, please list: _____

Patient Clinical Information:

Allergies:

Weight: _____ **lb/kg**

Concomitant Medications:

_____

_____

Height: _____ **in/cm**

Additional Comments: _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills

X_____
PRODUCT SUBSTITUTION PERMITTED (Date)

X_____
DISPENSE AS WRITTEN (Date)

Only 1 medication is allowed per order form for VA/OH/MO/VT. Please use a new form for each medication.