SPECIALTY ENROLLMENT FORM

Fax Referral To: 252-726-0792 Phone: 844-418-9857

PATIENT INFORMATION:

Name: ______
Address: ______
City: ______ State: ______ Zip: ______
Phone: ______ Alt. Phone: ______
Email: ______
DOB: ______ Gender: ○ M ○ F Caregiver: ______
Height: ______ Weight: ______ Allergies: ______

PRESCRIBER INFORMATION:

Name: ______
Address: ______
City: ______ State: ______ Zip: ______
Phone: ______ Fax: ______
NPI: ______ DEA: ______
Tax ID: ______
Office Contact: ______ Phone: ______

DIAGNOSIS AND CLINICAL INFORMATION Needs by Date: ______

Date of Diagnosis: ______ ICD-10: ______ Other: ______
Prior Therapy ☐ Yes ☐ No ______
Reason for Discontinuation of Therapy: ______
______
Approximate Start Date: ______ Approximate End Date: ______
Comorbidities: ______
Concomitant Medications: ______

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS

PRODUCT DELIVERY: ○ Patient's Home ○ Physician's Office ○ Pharmacy to Coordinate

INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

By signing this form, you are authorizing Medical Park Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

______ PRODUCT SUBMISSION PERMITTED ______ Date ______ DISPENSE AS WRITTEN ______ Date

CONFIDENTIALITY NOTICE: The fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have receive this document in error and then destroy this document immediately.