

# THERAPY ENROLLMENT FORM



DATE NEEDED: \_\_\_\_\_ MEDICATION/INJECTION START DATE: \_\_\_\_\_

Phone: 888.282.5166 Fax: 248.282.0471

## Patient Information

Patient Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Patient's Primary Language: \_\_\_\_\_  
Alternate Contact Name: \_\_\_\_\_  
Alternate Contact Phone: \_\_\_\_\_  
Ship to:  Patient  Physician  Other: \_\_\_\_\_

## Patient Insurance Information

Please copy front and back of medical and pharmacy insurance card and fax to Walgreens Specialty Pharmacy with this form.  Medicare/Medicaid

**Primary Insurer:** \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber Name/Date of Birth: \_\_\_\_\_  
Does this Plan Cover Prescription Drugs?:  YES  NO  
**Secondary Insurer:** \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber Name/Date of Birth: \_\_\_\_\_  
Does this Plan Cover Prescription Drugs?:  YES  NO  
Employer: \_\_\_\_\_

## PATIENT AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize Walgreens Specialty Pharmacy to release any and all information it may have as necessary for Walgreens Specialty Pharmacy to (i) establish my eligibility for benefits; (ii) provide to me products, supplies or services; (iii) receive payment of benefits on my behalf; (iv) communicate with other healthcare providers regarding medical care provided, or to be provided, to me; (v) facilitate the provision of products, supplies, services or training required for my treatment through the product manufacturer, which may be used for promotional programs. I understand that my personal health information is subject to redisclosure. I have the right to revoke this authorization in writing at any time. I also have a right to receive a copy of this authorization. My refusal to sign this authorization will have no impact on receiving treatment from Walgreens Specialty Pharmacy. This authorization is valid for the duration of my treatment with Walgreens Specialty Pharmacy unless revoked in writing.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Patient Diagnosis Information

Please copy chart notes medication history and baseline lab results and fax to Walgreens Specialty Pharmacy with prescription

Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of weight: \_\_\_\_\_  
Choose one of the following:  New  Restart  Currently on Therapy (Start Date: \_\_\_\_\_) Onset of Illness: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Other Medications Currently Taking: \_\_\_\_\_

## Physician Information

Physician Name: \_\_\_\_\_ Site/Facility Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Specialty: \_\_\_\_\_  
City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Office Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Fax: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_ Office Contact E-Mail: \_\_\_\_\_  
St. Lic. #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_ UPIN #: \_\_\_\_\_  
Office Hours: M - F \_\_\_\_\_ Sat: \_\_\_\_\_ Days Closed: \_\_\_\_\_

## Prescription Information

Drug: \_\_\_\_\_ Strength: \_\_\_\_\_ Qty: \_\_\_\_\_ Directions: \_\_\_\_\_ Refill x \_\_\_\_\_  
Drug: \_\_\_\_\_ Strength: \_\_\_\_\_ Qty: \_\_\_\_\_ Directions: \_\_\_\_\_ Refill x \_\_\_\_\_  
Drug: \_\_\_\_\_ Strength: \_\_\_\_\_ Qty: \_\_\_\_\_ Directions: \_\_\_\_\_ Refill x \_\_\_\_\_

Provide injectable ancillary supplies (needles, syringes, alcohol swabs)

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Walgreens Specialty Pharmacy will confirm order upon receipt and follow up every 48 - 72 hours with insurance updates.

In order for a brand name product to be dispensed, the prescriber must handwrite "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" in the space below

Home Health Agency Nursing Visit Required Name of Agency: \_\_\_\_\_ Agency Phone Number: \_\_\_\_\_

Is Patient Enrolled in Manufacturer Support Program?:  Yes  No

## FOR INTERNAL USE ONLY

Name: \_\_\_\_\_ Ext.: \_\_\_\_\_ Date: \_\_\_\_\_ Code: \_\_\_\_\_

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.  
Drug names are the property of their respective owners.

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**Phone: 888.282.5166**

**Fax to 4D for Prior Authorization:**

**Fax: 248.282.0471**