

PATIENT INFORMATION

Last Name _____ First Name _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work/Mobile Phone _____ E-mail _____
 Social Security # _____ Date of Birth _____ Gender: Male Female
 Primary Caregiver _____ Relation _____ Phone _____
 Emergency Contact _____ Relation _____ Phone _____

INSURANCE INFORMATION (Please send a copy of the patient's insurance card, both front and back.)

1. Primary Insurance _____ ID # _____ Group # _____ Phone _____
 Insured's Name _____ Insured's Employer _____ Relationship _____
 2. Secondary Insurance _____ ID # _____ Group # _____ Phone _____
 Insured's Name _____ Insured's Employer _____ Relationship _____

CLINICAL INFORMATION

***** Please send all Clinical Notes, Test and Lab Results to Help Facilitate Prior Authorization Processing *****

ICD-#" Code _____ Primary Diagnosis _____ Current Weight _____ kg/lb Height _____ inches/cm BSA _____ m2
 Allergies: Yes No If yes, please list _____
 Therapy: New Restart Prior Therapies: _____

MEDICATION

Drug Name	Dose/Strength	Directions	Quantity	Refills

SUPPORTIVE MEDICATION

Drug Name	Dose/Strength	Directions	Quantity	Refills

Deliver To: Home Physician* **If shipped to physician's office, physician accepts on behalf of patient for administration in office.*
 Anaphylaxis Kit Needed: Yes NO *If yes, please provide patient with a prescription for an EpiPen which he/she may pick up at their pharmacy of choice.*

PHYSICIAN INFORMATION

Physician Name _____ Contact Name _____
 NPI # _____ DEA # _____ Lic # _____ Tax ID# _____
 Phone/Fax _____ E-mail _____
 Address _____ City _____ State _____ Zip _____

I authorize EntrustRx and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer. I also certify that all the information above is correct to the best of my knowledge and the prescribed therapy is a medical necessity.

Physician Signature _____ Dispense as Written _____ Substitution Permissible _____ Date _____