briovaRx™

Fax: 877-292-5799 MA Phone: 877-633-4807 MA

General Enrollment Form

we take care of people

Ship to: ☐ Patient ■ Office ☐ Other: Date: Needs by Date:

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

Address _____

Address 2 _____

City, State, ZIP _____

Home Phone _____

Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender

PRESCRIBER INFORMATION

Prescriber's Name _____

State License # _____ UPIN _____

DEA _____ NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION *(Fill out entirely or fax a copy of patient's insurance card including both sides)*

Prescription Card: Name of Insurer Optima ID # _____ BIN _____ PCN _____ Group _____

Primary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

Secondary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

MEDICAL INFORMATION *(Attach separate sheet if needed)*

Diagnosis

Please include diagnosis name and ICD-9

_____

_____

_____

_____

_____

Date of Diagnosis _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Concomitant Medications _____

_____

Additional Comments _____

_____

Injection Training/Home Health Coordination:

Injection training/home health will be/has been conducted by the physician's office: ☐ Yes ☐ No If Yes, Date _____

Specialty pharmacy to coordinate injection training/home health nursing: ☐ Yes ☐ No Agency of Choice _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills

By signing below, I authorize BriovaRx™ and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber's Signature _____

PRODUCT SUBSTITUTION PERMITTED *DISPENSE AS WRITTEN*