



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*

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