General Enrollment Form

(Please use black ink)

Phone # (866-458-9246) **Fax # (866-458-9245)**

exactus™ PHARMACY SOLUTIONS
Experts in pharmacy management

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 _____
Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
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 _____ ID # _____ BIN _____ PCN _____ Group _____
Primary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Group _____
Secondary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Group _____

MEDICAL INFORMATION *(Attach separate sheet if needed)*

Diagnosis – *Please include diagnosis name with ICD-10 code*

_____
_____
_____
_____
_____
_____
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

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription. I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in th patient's insurer's provider network.

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

Prescriber's Signature _____ _____
PRODUCT SUBSTITUTION PERMITTED *DISPENSE AS WRITTEN*

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