

Echo Pharmacy Specialty Services *Enrollment Form*

39-50 Crescent Street • Long Island City, NY 11101 • Phone (718) 247-4615

Fax to (718) 391-0446

Date: _____ Needs by Date: _____		Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> Office	
PATIENT INFORMATION		PRESCRIBER INFORMATION	
(Complete the following <u>or send patient demographic sheet</u>)		Prescriber Name: _____	
Patient Name: _____		State License#: _____ DEA#: _____	
Address: _____		NPI#: _____	
City, State, Zip: _____		Address: _____	
Home Phone: _____		City, State, Zip: _____	
Alternate Phone: _____		Phone: _____	
Patient SS#: _____		Fax: _____	
Date of Birth: _____		Contact Person: _____	
INSURANCE INFORMATION		Please Fax Copy Of Insurance Card (Front & Back)	
Primary Insurance		Secondary Insurance	
CLINICAL INFORMATION (OPTIONAL---but will assist in insurance authorization and patient education)			
Diagnosis:		Other Clinical Comments:	
<input type="checkbox"/> 555.9 Crohn's	<input type="checkbox"/> 720.0 Ankylosing Spondylitis	*General: Is patient also taking methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> 714.0 Rheumatoid Arthritis	<input type="checkbox"/> 696.0 Psoriatic Arthritis	*Humira/Enbrel: TB/PPD Test given? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> 733.0 Osteoporosis	<input type="checkbox"/> 715.9 Osteoarthritis (Unspecified)	* Enbrel: Does patient have a latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prior (FAILED) Medications:		Forteo: * T-Score: _____ Date: _____	
Medication	Duration of Treatment/Reason for D/C	* Fracture History: Site: _____ Date: _____	
<input type="checkbox"/> _____	_____	Site: _____ Date: _____	
<input type="checkbox"/> _____	_____	Orencia/Remicade/Rituxan WEIGHT: _____ lbs or _____ kgs	
<input type="checkbox"/> _____	_____	*Comments: _____	
*Comments: _____			
PRESCRIPTION INFORMATION			
*Has patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medication(s): _____			
*Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medication(s): _____			
*Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long should patient wait before starting the new medication? _____			
*Other medication(s) patient is currently taking including OTC medications with dosage and direction(or fax medication profile): _____			
*Has patient received a PPD(tuberculosis) Skin Test? <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____ Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.			
		Rx:	
		Sig:	
		Sig: This Prescription Will Be Filled Generically Unless Prescriber Writes "daw" in the Box Below <div style="border: 1px solid black; width: 100px; height: 40px; margin: 0 auto;"></div> Dispense as Written	
		_____ Prescriber Signature	

Important Notice: This facsimile transmission is intended only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.