**Specialty Enrollment Form**

Fax Referral To: 1-334-528-3946 Phone: 1-334-528-3950

Email Referral To: SpecialtyPharmacy@eamc.org

**Patient Information**

Patient Name: Address: City, State, ZIP:

Preferred Contact Methods: [ ]  Phone (to primary # provided below)[ ]  Text (to cell # provided below) [ ]  Email

Primary Phone: Alternative Phone: DOB: Gender: [ ] Male [ ] Female

Email: Marital Status: [ ] Single [ ]  Married

**Insurance Information**

Please fax copy of prescription and insurance cards with this form, if available (front & back)

**Prescriber Information**

Prescriber’s Name: State License#:

NPI#: DEA#: Group or Hospital:

Address: City, State, ZIP:

Phone: Fax: Nurse (Primary Contact):

**Diagnosis & Clinical Monitoring**

**Diagnosis (ICD-10):** Needs by Date: Ship to:

Primary Code: Click or tap here to enter text. Description: Click or tap here to enter text.

Secondary Code: Click or tap here to enter text. Description: Click or tap here to enter text.

* Specific disease type, subtype or classification pertinent to benefits investigation or therapeutic appropriateness:

Click or tap here to enter text.

* Enter additional information pertinent to benefits investigation or therapeutic appropriateness.

Click or tap here to enter text.

**Diagnostic Criteria**

* Does the patient have any diagnostic criteria pertinent to benefits investigation or therapeutic appropriateness?

Click or tap here to enter text.

**Disease Monitoring**

* Does the patient have any lab values or other test results pertinent to monitoring the progression of the disease?

Click or tap here to enter text.

**Drug Safety Monitoring**

* Does the patient have any lab values or other test results pertinent to monitoring the safety of their therapeutic regimen? Click or tap here to enter text.

**Clinical History**

**Patient Clinical Information:**

Allergies: Click or tap here to enter text.

Height: in/cm Weight: lb/kg

**Medical History & Comorbidities**

* Does the patient have any medical history or comorbidities pertinent to their therapeutic regimen?

Click or tap here to enter text.

* Alcohol Use: Substance Use: Tobacco Use:

**Social History**

* Does the patient have any social factors pertinent to this therapeutic regimen?

Click or tap here to enter text.

**Prior Medication**

* Does the patient have any prior medication history pertinent to this therapeutic regimen in regards to this specialty disease state?

Click or tap here to enter text.

**Additional Information**

* Document any additional information as needed.

Click or tap here to enter text.