PHARMACY ADVANTAGE

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www.PharmacyAdvantageRx.com

PRESCRIBER ENROLLMENT FORM

Please complete ALL information below. Incomplete forms cannot be processed. Please print clearly

STEP 1: PRESCRIBER INFORMATION

Name: ______________________ DEA #: ______________________
(Required for CIII - CV medications)

Phone: ______________________ License Number: ______________________

Fax: ______________________ Contact Person: ______________________

Address: ______________________

City: ______________________ State: __________ Zip code: ______________________

STEP 2: INSURANCE INFORMATION

Cardholder name: ______________________ Patient's name: ______________________

Relationship of patient to cardholder: ______________________

ID number (include all characters): ______________________ Rx group number: ______________________

STEP 3: PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________________

Phone: ______________________ Email: ______________________

Allergies: ❑ None ❑ Aspirin ❑ Codeine ❑ Iodine ❑ Penicillin ❑ Sulfa ❑ Other: ______________________

Medical Conditions: ❑ Heart Failure ❑ Hypertension ❑ Glaucoma ❑ Ulcer ❑ Heart Attack/Angina ❑ Asthma

❑ Other: ______________________

STEP 4: PRESCRIPTION INFORMATION

Prescriber signature: ______________________ **Date:** ______________________

(We cannot accept signaure stamps)

❑ Dispense as written ____________ ❑ Substituion permissible ❑ Refills: NR 1 2 3 4 5 PRN

(Initial)

Most patients can receive a 90-day supply plus refills up to 1 year where appropriate

STEP 5: FAX COMPLETED FORM TO (248) 386-5335

Pharmacy Advantage cannot accept CII prescriptions via fax.
Fax forms will only be accepted when sent from a prescriber's office.
The printed fax confirmation is proof of receipt

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