Gastroenterology Enrollment Form

2608 Route 112, Medford, NY 11763 | Email: info@medfordchemists.com | Phone: 1-855-MEDCHEM | Fax: 631-475-42 88

PATIENT INFORMATION			
Name:	Date of Birth:		O Male O Female
Address:	City:	State:	Zip:
Phone:	Alt Phone:		Email:
SS #:	Primary Language:		Emergency Contact:

PRESCRIBER INFORMATION				
Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESQRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

ICD-10 Code & Description: _____

Patient Evaluation: Height: _____ in/cm Weight: _____ kg/lbs

Allergies: _____

TB Test results:_____ Date: _____

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

MEDICATION

☐ Adefovir	☐ Infliximab	☐ Xifaxan
☐ Baraclude	☐ Remicade	☐ Zeposia
☐ Cimzia	☐ Renflexis	☐ Zorbtive
☐ Dupixent	☐ Rinvoq	
☐ Entyvio	☐ Simponi	☐ Other _____
☐ Eohilia	☐ Skyrizi	
☐ Epivir	☐ Stelara	
☐ Humira	☐ Vemlidy	
☐ Inflectra	☐ Xeljanz	

PRESCRIPTION iNFORMATION

Dosage Form	Dose	Directions	Qty/Day Supply	Refills
	Initial Dose:		Qty_____ Day supply: _____	
	Maintenance Dose:		Qty_____ Day supply: _____	
	Other:		Qty_____ Day supply: _____	

INJECTION TRAINING

☐ Patient has received pen & injection training ☐ Physician's office to provide injection training ☐ Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE	
Prescribing Practitioner: The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing this form and utilizing our services, you are also authorizing Medford Chemists Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.	
☐ **DAW Brand Medically Necessary** ☐ **May substitute/ Substitution Permissible**	
Prescribing Practitioner	Date

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