



RA/Dermatology Enrollment Form
Patient Referral/Medication Request Form

Phone: 806-324-5447 • Toll Free Phone 1-866-629-6779 • Toll Free Fax: 1-866-217-8034

Patient Information

Patient Name, Date of Birth, Address, City, State, Zip, Phone Home, Work, Cell, Social Security #, Allergies, NKA, Weight, Emergency Contact Name, Phone

Please attach copy of insurance information or copy of insurance cards (both sides).

Shipping Information

Patient's Home, Physician's Office, Other, Date Medication Needed

Physician Information

Physician Name, Office Contact Name, Address, City, State, Zip, Phone, Fax, Physician Signature, Date, Dispense as written, Generic substitution permitted

Diagnosis/Medical Information

ICD9 Code, Severity, Type, Prior (FAILED) Medications, Injection Training/Home Health, Additional Comments

Prescription Information

Amevive, Enbrel, Humira, Remicade, Stelara, Dispense, Refill