International
Enrollment Form

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Country: _____
Primary Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ Gender: ☐Male ☐Female
E-mail: _____
Primary Language: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Country: _____
Phone: _____ Fax: _____

INSURANCE INFORMATION

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

DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis: (ICD-9 or ICD-10)

Please include diagnosis name and code:

ICD9 or ICD10	Description

Additional Clinical Information:

Therapy: ☐ New ☐ Reauthorization ☐ Restart
Height: _____ in/cm
Weight: _____ kg/lbs
Allergies: _____
Concomitant Medications: _____
Additional Comments: _____
Has patient received injection training? ☐ Yes ☐No ☐N/A

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐				
☐				
☐				
☐				
☐				
☐				
☐				

☐Patient is interested in patient support programs

Prescriber's Sig _____ Date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.