Lumicera Health Services
2601 West Beltline Hwy, Ste 302, Madison, WI 53713 / Phone: (855) 847-3553 / Fax: (855) 847-3558

General Enrollment Form

Ship to: ○ Patient ○ Office ○ Other Date: Needs by Date:

PATIENT INFORMATION

Patient Name _____
Address _____
Address 2 _____
City, State, ZIP _____
Preferred Phone _____ Type _____
Alternate Phone _____ Type _____
Email _____
DOB (mm/dd/yyyy) _____ Gender ○ Male ○ Female

PRESCRIBER INFORMATION

Prescriber Name _____ Specialty _____
State License # _____ UPIN _____
DEA _____ NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Office Contact _____ Phone _____

INSURANCE INFORMATION *(Please fax FRONT and BACK copy of all Insurance cards (Prescription and Medical)*

CLINICAL INFORMATION

Diagnosis (*Please include diagnosis name and ICD-10)*

Primary Diagnosis: _____
ICD-10: _____
Date of Diagnosis: _____
Weight: _____ lbs/kgs Height :_____in/cm
Is the patient pregnant, nursing, or planning pregnancy?: ○ Yes ○ No ○ N/A
Allergies: _____
Concomitant medications: _____
_____

Therapy: ○ New ○ Reauthorization ○ Restart

Lab Data: _____
Has the patient been previously treated for this condition? ○ Yes ○ No
Prior failed medication (medication and duration of treatment/reason for d/c):
_____
Who will administer injection? (if applicable): _____
Patient trained on injection? (if applicable): ○ Yes ○ No
Pharmacy injection training needed? (if applicable): ○ Yes ○ No
Additional comments: _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills

By signing below, I authorize Lumicera Health Services and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber Signature: _____ _____ _____

PRODUCT SUBSTITUTION PERMITTED *Date* *DISPENSE AS WRITTEN*