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*

L1011-1113