

Inotropic Therapy

PRESCRIPTION & ENROLLMENT FORM Page 1 of 2

Referral date _____ New patient
 Current patient

1 PATIENT INFORMATION

Patient name _____

Date of birth _____ Male Female

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/Guardian (if applicable) _____

Phone _____ Employer _____

May we contact the patient regarding insurance benefits and product delivery? Yes No

Primary insurance company _____

Insurance company phone _____

Insured name _____ Date of birth _____

Insured employer _____ Group # _____

Identification # _____

Drug card company _____

Drug card company phone _____

RxBIN # _____ PCN # _____ Person code _____

Policy # _____ Group # _____

Secondary insurance company _____

Insurance company phone _____

Insured name _____ Date of birth _____

Insured employer _____ Group # _____

Identification # _____

Please attach copy of front and back of patient's insurance cards, if available.

In lieu of completing this section, please provide a copy of the patient's demographic page.

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Prescriber name and title _____

Practice specialty _____

Office contact _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

UPIN # _____

Referral source (check one) Prescribing physician Patient self-referral No referring MD

Referring MD (if different from prescribing MD) _____

Date _____ Time _____

Name and title of person faxing this form _____

3 CLINICAL INFORMATION

To support the diagnosis, include a history and physical, invasive hemodynamic testing results, medication profile, echocardiogram results, relevant lab work, and any pertinent supporting clinical data.

Primary diagnosis

ICD _____

Description _____

Other relevant diagnosis

ICD _____

Description _____

Weight _____ lbs kg Height _____ inches cm Diabetic Yes No

NKDA Known allergies _____

Allergic reaction _____

