CSI CLINICAL SPECIALTY INFUSIONS

Phone: 833-569-1005 | Fax: 430-200-4889 | Online: deliver.myforcura.com

GENERAL ENROLLMENT FORM

Account manager: _____ Contact info: _____

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		Caregiver (if applicable):	
Address:	City:	State:	Zip:
Main Phone:	Alternate Phone:	Email:	SSN (required):
Date of Birth:	☐ Male or ☐ Female	Height (required): _____ ☐ cm or ☐ inches	Weight (required): _____ ☐ lb or ☐ kg
Diagosis:			

Please include face sheet, copy of insurance cards (front and back), H&P, clinicals and any available lab results.

INSURANCE INFORMATION

Insurance Name:	Insurance ID Number:	
BIN Number:	PCN Number:	RX Group Number:

PRESCRIPTION AND ORDERS

Medication:

SIG:

Route: ☐ Intravenous ☐ Subcutaneous ☐ Oral	**Access: (if needed)** ☐ Peripheral ☐ Port **Supplies: (if needed)** Dispense ancillary supplies, including ambulatory infusion pump or subcutaneous infusion pump.	**Dispense:** ☐ 4-week supply ☐ Other: _____ **Refills:** x 1 year unless noted otherwise: _____refills

Nursing Orders for Home Infusion: Provide skilled nursing for home medication administration as prescribed and per CSI nursing policies. Insert, access, and manage vascular access devices. Deliver nursing care for therapy duration and educate patient on medication, disease state, adverse reactions, and administration. Monitor patient response and report adverse events. Additional teaching visits may be required for self-administration.

Flush Orders (IV infusions ONLY): Flush with 0.9% sodium chloride 5-10 mL pre and post medication and as needed, max per dispense x 60 syringes (refill x 1 year). For CVADs ONLY, may add Heparin 3-5 mL as final flush to maintain patency as needed; PORT 100 units/mL; PICC 10 units/mL, max per dispense x 30 syringes (refill x 1 year).

PRESCRIBER INFORMATION

Prescriber Name:		Practice Site Name:	
Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	
Office Contact and Special Instructions:			

Prescriber Authorization: I authorize the pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: **Date:**

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