KnippeRx™ Specialty Pharmacy Services

General Enrollment Form

Phone: (855) 647-7379
Fax: (855) 774-3879

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:________ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:________

1. Patient Information

Last Name: ________ First Name: ________ Home Phone:________ Work/Mobile Phone:________

S.S. #: ________ Date of Birth: ________ Home Address:________

Guardian/Caregiver:________ City:________ State:________ Zip:________

Patient Preferred Language:________ Sex: ☐ Male ☐ Female Height:________ Weight:________ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance:________ Phone:________ Prescription Card: ________ Phone:________

Subscriber Name:________ Policy #:________ BIN/PCN:________

Policy #:________ Group #:________ Medicare #:________ Medicaid #:________

3. Prescriber Information

Prescriber Name:________ ☐ MD ☐ DO ☐ NP ☐ PA License #:________ NPI #:________ DEA #:________

Practice Name: ________ Phone:________ Fax:________

Address:________ Office Contact:________ Phone:________

City: ________ State:________ Zip:________ Collaborating Physician:________

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

ICD-10 Diagnosis Code: ________

5. Prescription Information

Medication: ________

QTY ________

Directions ________

Refills________

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient/Parent/Guardian Signature: ________ Date ____ / ____ / ____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize KnippeRx, Inc. to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____