Sentara Case Management Pharmacy
Sentara Norfolk General Hospital

GENERAL ENROLLMENT FORM

Fax Referral To: 757-388-7835
Phone: 877-349-5242

PATIENT INFORMATION

Patient Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Primary Phone: ____________ **Alternate Phone:** ____________

Email: ______________________ **Gender:** ☐ M ☐ F

DOB: ____________ **Last Four of SSN:** ____________

Preferred Language: ______________________________

PRESCRIBER INFORMATION

Prescriber's Name: ______________________________

DEA #: ____________ **NPI #:** ____________

Group or Hospital: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone #: ____________ **Fax #:** ____________

Contact Person: ____________ **Contact's Phone:** ____________

INSURANCE INFORMATION (*Please FAX copy of prescription and insurance cards (front and back) with this form, if available)*

Primary Insurance: Name of insurer ____________ ID # ____________ BIN ____________ PCN ____________ Group ____________

Secondary Insurance: Name of insurer ____________ ID # ____________ BIN ____________ PCN ____________ Group ____________

DIAGNOSIS AND CLINICAL INFORMATION *(Please FAX recent labs and clinical notes with prescription to expedite Prior Authorization)*

Diagnosis Description **ICD-10 Code**

____

____

Date of Diagnosis: ______________________________

Injection training provided by:

☐ **Doctor office** ☐ **Pharmacy** ☐ **Other:** ____________

Needs By Date: ____________

☐ **New Therapy** ☐ **Reauthorization** ☐ **Restart**

Current Therapy: ______________________________

Will the patient be stopping the above medication before starting new therapy?

☐ **Yes Discontinuation Date:** ______________________________
☐ **No**

Has the patient failed other therapies in the past? ☐ **Yes** ☐ **No**

If so, please list: ______________________________

Patient Clinical Information:

Allergies:

Weight: ____________ **lb/kg**

Concomitant Medications:
____
____

Height: ____________ **in/cm**

Additional Comments: ______________________________

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills

X______________________________
PRODUCT SUBSTITUTION PERMITTED (Date)

X______________________________
DISPENSE AS WRITTEN (Date)

Only 1 medication is allowed per order form for VA/OH/MO/VT. Please use a new form for each medication.

IMPORTANT NOTICE: This communication and its contents and attachments contain information that is confidential or otherwise protected from disclosure. The information is intended to be for the addressee only.
If you are not the addressee, any disclosure, copy, distribution or use of the contents of this message is prohibited. If you have received this information in error, please notify us immediately and destroy the original information and all copies.