Banner Family Pharmacy Specialty Care Services Enrollment Form

Fax Referral To: 1-602-747-2170
Pharmacy Phone: 1-844-747-6442
Address: 7300 W Detroit Street, Chandler, AZ 85226

Banner Health®

Insurance information can be faxed with this form, if available (copy of insurance card, front and back)	
PATIENT INFORMATION	**PRESCRIBER INFORMATION**
Patient Name: _____	Prescriber's Name: _____
Date of Birth: _____	☐ NPI ☐ DEA ☐ State License #: _____
Address: _____	Group or Hospital: _____
Address 2: _____	Address: _____
City, State, Zip: _____	Address 2: _____
Primary Phone: _____	City, State, Zip: _____
Alternate Phone: _____	Primary Phone: _____
Gender (check one): ☐ Male ☐ Female	Fax: _____
	Contact Person: _____ Phone: _____

MEDICAL INFORMATION

Height: _____ in/cm Weight (**required** for patients < 18y):_____lb/kg ICD-10 code(s): _____

☐ No known drug allergies ☐ Allergies, if yes, please list: _____

☐ Treatment naïve ☐ Tried/failed therapies, please list: _____

Concomitant Medications: _____

_____

Most recent TB test status (please circle) and date: Positive / Negative on _____ (mm/dd/yy)

Device training has been conducted with the patient (circle if applicable): Yes/No If yes, date: _____

Other pertinent medical info: _____

MEDICATION	STRENGTH AND DOSAGE FORM/DEVICE	DOSE AND DIRECTIONS	QUANITY/REFILLS
			Quantity: Refills:
			Quantity: Refills:
			Quantity: Refills:
			Quantity: Refills:

Suggested supplies: ☐ Alcohol pads ☐ Band-aids ☐ Sharps container

☐ Needles/syringes (gauge/length, volume syringe) _____

☐ Other supplies: _____

Ship medication to: ☐ Patient's Home ☐ Doctor's Office ☐Other: _____

PROVIDER SIGNATURE REQUIRED

_____ _____

PRODUCT SUBSTITUTION PERMITTED DATE DISPENSE AS WRITTEN DATE