



**GENERAL REFERRAL ENROLLMENT & PRESCRIPTION FORM**

**PHONE:** 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.WellDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

<b>PATIENT INFORMATION</b>	Patient: _____ Caregiver: _____
	DOB: _____ Male Female Weight: _____ kgs or lbs (check one) Height: _____ in or cm (check one) Recorded Date: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Best Phone #: _____ Cell Alternate Phone #: _____ Cell Email: _____
	Allergies: _____ Latex Allergy: Yes No
	ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

**PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION. PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS.**

<b>PREScription INFORMATION</b>	<b>MEDICATION</b>	<b>DOSE/STRENGTH</b>	<b>DIRECTIONS</b>	<b>QTY</b>	<b>REFILLS</b>
					DAW: _____
					DAW: _____
					DAW: _____
					DAW: _____
					DAW: _____
					DAW: _____

<b>PREScriber INFORMATION</b>	<b>INJECTION TRAINING:</b>	<b>OFFICE TO COORDINATE</b>	<b>WELLDYNE SPECIALTY TO COORDINATE</b>
	Anticipated Start Date: _____	Prescriber Specialty: _____	
	Ship to: Patient Physician Clinic Other: _____		
	Fax #: _____	Contact Name: _____	
	Office Address: _____	City: _____	State: _____ Zip: _____
	The terms and conditions posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.		
	The data privacy terms posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.		
	I understand that WellDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.		
	Prescriber's Name: _____	Prescriber's Signature: _____	Date: _____
	Use substitution	Dispense as written	

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