MALECON PHARMACY

In partnership with McKESSON
Empowering Healthcare

MALECON Health Mart PHARMACY

RHEUMATOLOGY NEW PATIENT ENROLLMENT FORM

Fax: 800-557-0966 Tel: 800-797-3127 E-Prescribe: Malecon Pharmacy

PATIENT PROFILE

Last Name: _____ First Name:_____

Street:_____ City:_____

State: _____ Zip: _____ Phone: _____ Cell:_____

DOB: _____ MALE or FEMALE Social Security # _____ Date Needed: _____

Allergies:_____

Diagnosis /ICD9 Code:_____ RX: NEW or REFILL

INSURANCE INFORMATION

Please fill out below or fax both sides of patient's insurance card(s).

Primary Insurance:_____

Insured: _____

Policy#:_____

Group#:_____

BIN #: _____PCN#_____

Secondary Insurance:_____

Insured: _____

Policy#:_____

Group#:_____

BIN #: _____PCN#_____

PRESCRIPTION

Please fill out and fax a copy of the prescription. Use additional pages if needed.

☐ Enbrel	☐ Humira	☐ Forteo	☐ Simponi
☐ Plaquenil	☐ Vicodin	☐ Ultram	☐ Rheumatrex
☐ Mobic	☐ Celebrix	☐ Flexeril	☐ Lyrica
☐ Ridaura	☐ Arava	☐ Orazone	☐ Azulfidine

☐ Other _____

☐ Rituximab	☐ Imuran	☐ Minocin	☐ Azulfidine
☐ Orencia	☐ Humira	☐ Kineret	☐ Remicade
☐ Cortisone	☐ Deltasone	☐ Indocid	☐ Naprosyn

☐ Other _____

DOSAGE AND SIG CODE:

Refills: _____ Authorization# (if required)_____ _

DOSAGE AND SIG CODE:

Refills: _____ Authorization# (if required)_____ _

PHYSICIAN INFORMATION

Physician's Name: Dr. Amiel Tokayer **Office Contact:** _____

Phone:_____ **Fax:** _____**E-mail:**_____

Address:_____

License#: _____ **NPI#:** _____ **DEA#:** _____**UPIN#:**_____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

This Form should be filled in for all new patients you are referring to us. For refills or new RX's of existing patients you may use this form or fax/e-send a copy of the prescription – whatever is more convenient for you.