PHONE (888) 274-6799 (973) 435-6322 www.saluvitas.com

ENROLLMENT FORM

Please e-Scribe/eRx ALL Prescriptions To:

UNITED DRUGS
507 Central Avenue
Newark, NJ 07107
Phone: 973-482-9300
NCPDP# 3138193; NPI# 1588796544

OR

Please FAX patient insurance cards (both sides), pertinent medical information with diagnosis codes and ALL laboratory data to our HIPAA -Compliant

Fax# 973-954-2526

Fax Physician's Prescription to our HIPAA-Compliant

Fax # 973-954-2526

☐ HIV ☐ HEPATITIS-B ☐ HEPATITIS-C ☐ MULTIPLE SCLEROSIS ☐ CANCER ☐ RHEUMATOID ARTHRITIS
☐ PSORIASIS ☐ CROHN'S DISEASE ☐ OTHER____________________ **CHECK (√) ALL THAT APPLY**

Today's Date: [Date]	Prescriber:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:
Date of Birth:	Age:	Gender:
Address:		☐ Check Box to Deliver Medicine to MD Office
Social Security #	Home Phone #	Cell Phone #

INSURANCE INFORMATION

Please indicate Prescription Drug Insurance

Patient ID Number	BIN	PCN	Group Number:
Name of secondary insurance (if applicable):	Policy Number:		Group Number:

PRESCRIBER AUTHORIZATION

I authorize Saluvitas Specialty Care LLC to act as my authorized agent to secure coverage, enroll patients in co-pay programs, initiate, execute & manage the submission of prior authorization requests, patient laboratory values and other relevant patient data/ PHI to secure approval for medication(s) prescribed by me. Once approved, I authorize Saluvitas Specialty Care, LLC to fill the prescription at a Pharmacy within its network and dispense it to either to the patient or deliver it to my office. In the event a pharmacy within the Saluvitas Specialty Care, LLC pharmacy network is unable to fill and dispense this prescription, I authorize this pharmacy to transfer the prescription and related information to a pharmacy of the patient's choice or in the patient's insurance provider's network.

_______________________________________ ____________________
Physician/Physician's Agent Signature Date

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