General Patient Enrollment

Select Location

Avita
avitapharmacy com

DATE	NEEDS BY DATE	SHIP TO: ❑ PATIENT ❑ OFFICE - FIRST DOSE ❑ OFFICE - ALL DOSES ❑ OTHER:
REFERRED BY		TEL

PATIENT INFORMATION

ALL INFORMATION IS CONFIDENTIAL AND USED FOR CLINICAL PURPOSES ONLY

Patient Name		Preferred Name	
Main Phone	Alternative Phone	Date of Birth	Social Security #
Address		City, State, Zip	

Sex
❑ Male ❑ Female ❑ Intersex ❑ MtF Female ❑ FtM Male ❑ other:

Gender Identity ❑ Male ❑ Female ❑ Transgender ❑ Non-Binary ❑ other:	Pronouns

Allergies

PRESCRIBER INFORMATION

Prescriber Name

Address	City, State, Zip
Office Contact	Phone

PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

INSURANCE

❑ Private Insurance ID#:	❑ Medicaid ID#:
❑ Medicare Part D ID#:	❑ Other: ID#:

PRESCRIPTION INFORMATION

❑ Written Below ❑ E-Prescribed ❑ Phoned In ❑ Faxed Separately ❑ Compliance Packaging ❑ Spanish Instructions

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑				
❑				
❑				
❑				
❑				
❑				
❑				

Dispense As Written (no stamps) **Date** **Substitution Permitted** (no stamps) **Date**

1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
4. Prescribers must comply with any of their state-specific prescription requirements.