



www.acropharmacy.com  
 Sharon Hill, PA  
 Phone: 800.906.7798  
 Fax: 877.381.3806  
 NCPDP: 3982902  
 NPI: 1639103823

Memphis, TN  
 Phone: 800.906.7798  
 Fax: 844.612.9057  
 NCPDP: 4447783  
 NPI: 1518349562

**SPASSIST<sup>®</sup>**  
**ENROLLMENT FORM**

Today's Date: \_\_\_\_\_  
 Needed By: \_\_\_\_\_

Last update 10.31.2018



www.commcarepharmacy.com  
 Plantation, FL  
 Phone: 888.203.7973  
 Fax: 888.203.7980  
 NCPDP: 1079638  
 NPI: 1598762015

**Patient Demographics:**(Please provide the following or attach demographics sheet)  
 Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Preferred Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Last four digits of SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Provider Office:** (Please provide as much information as possible)  
 Prescriber's Name: \_\_\_\_\_ Group/Hospital: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ License#: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

**Insurance Information:** (Please copy and attach the front and back of the patient's insurance card)

**Medication Delivery to:** (choose one) Patient's Address Always to Physician's Office First fill to Physician's Office, refills to Patient's Address

**Diagnostic Information:** (Please provide ICD-10-CM codes as applicable)  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_ Comorbidity  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  
 Date of Diagnosis \_\_\_\_\_ OR Years with Disease \_\_\_\_\_ Disease State Severity: Mild Severe Moderate

**Injection Training & Education Needs:**  
Patient has received injection training  
Physician's office to provide injection training  
Commcare Pharmacy to coordinate injection training  
Manufacturer's Patient Assistance Program Enrollment Requested

**Prior (Failed) Medications (Reason for D/C):**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to Acro Commcare

**Physician Signature:** \_\_\_\_\_ DAW (Dispense as Written) **Date:** \_\_\_\_\_

**Patient Support Programs:** I authorize Acro Pharmaceutical Services and Commcare Specialty Pharmacy to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

\*Patient Signature: (required for participation) \_\_\_\_\_ Date: \_\_\_\_\_  Please select if you would like the patient enrolled in a Manufacturer's Assistance Program

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