MEN'S HEALTH GENERAL ENROLLMENT FORM

Fax to: 430-200-5425

24 Wellness Rx

DATE:_____
DATE NEEDED:_____

SHIP TO: ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
3320 Troup Highway, Suite 140
Tyler, TX 75701
Phone: 903-266-1975
Toll Free: 833-682-3515

PATIENT INFO

NAME _____ E-MAIL_____ DOB_____ ☐ MALE ☐ FEMALE

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME TELEPHONE _____ MOBILE PHONE_____ SS#_____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

DATE OF DIAGNOSIS:_____ ALLERGIES: _____

DIAGNOSIS CODE: _____ OTHER: _____

PRESCRIPTION INFORMATION

DRUG	DOSAGE FORM/STRENGTH	QTY	REFILLS
☐ Sildenafil Sublingual Trit/Troche Sig: _____	☐ 20mg ☐ 25mg ☐ 50mg ☐ 100mg ☐ Other_____	☐ 30 ☐ 60 ☐ 90 Day Supply *30 minutes prior to sexual activity, Do not take more than once daily. Should be taken only when needed.*	
☐ Sildenafil 95mg/Oxytocin 10 unit Sublingual Trit/ Troche Sig: _____	☐ 20mg ☐ 25mg ☐ 50mg ☐ 100mg ☐ Other_____	☐ 30 ☐ 60 ☐ 90 Day Supply *30 minutes prior to sexual activity, Do not take more than once daily. Should be taken only when needed.*	
☐ Tadalafil Sublingual Trit/Troche Sig: _____	☐ 5mg ☐ 10mg ☐ 20mg ☐ Other_____	☐ 30 ☐ 60 ☐ 90 Day Supply *30 minutes prior to sexual activity, Do not take more than once daily. Should be taken only when needed.*	
☐ Testosterone Cream Sig: _____	☐ 50mg/ml ☐ 100mg/ml ☐ 200mg/ml ☐ Other_____	30 Day Supply *30 minutes prior to sexual activity, Do not take more than once daily. Should be taken only when needed.*	
☐ Testosterone Gel Sig: _____	☐ 50mg/ml ☐ 100mg/ml ☐ 200mg/ml ☐ Other_____	30 Day Supply	
☐ Testosterone/Chrysin HRT Cream Sig: _____	☐ 30/30 mg/ml ☐ 50/30mg/ml ☐ 100/30 mg/ml ☐ Other_____	30 Day Supply	
☐ Chrysin HRT Cream Sig: _____	☐ 30mg/ml ☐ 50mg/ml ☐ 100mg/ml ☐ Other_____	30 days supply	
☐ Testosterone HRT Cream Sig: _____	☐ 50mg/ml ☐ 100mg/ml ☐ 200mg/ml ☐ Other_____	☐ 30 days supply ☐ 90 Day Supply	
☐ Testosterone Cypionate *(commercially available)* Sig: _____	☐ 200mg/ml ☐ 100mg/ml ☐ 1ml ☐ 10ml		
☐ Syringe Kit Sig: _____		☐ #1 Kit	

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person:_____

Telephone: _____ Fax:_____ Email:_____

Office Address: _____ City:_____ State: _____ Zip:_____

NPI # : _____ DEA # : _____ TAX ID # : _____ Medicaid Provider # :_____

_____ _____ * _____

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.