Duquesne University Pharmacy Enrollment Instructions

The Duquesne University Pharmacy Enrollment Form is only necessary for:

- First-time orders,
- Dependents who are being added since your last order or
- Changing your current information

To have your maintenance prescriptions filled by the Duquesne University Pharmacy, follow these steps:

Step 1: Enroll

Complete the enrollment form and fax to 412-246-2037.

Step 2: Fill your prescription

You have a number of options for getting your prescription to us. You can mail the original prescription to us, call us to schedule convenient pick-up of your new prescription, or have your health care provider send the prescription directly to us.

Your provider can send the prescription through the following options:

- E-prescribe to Duquesne University Pharmacy
- Fax to 1-866-297-1512
- Call at 412-246-0963

Step 3: Complete Payment

Co-payment by major credit card or flexible spending card can be made over the phone by calling us at 412-246-0963. Additionally, payment by cash or check can be given directly to the delivery driver dropping off your prescription on campus.

Step 4: Delivery to Your Office

We will contact you directly to confirm the time and place of your delivery. Please provide your office contact or cell phone number.

Step 5: Ordering Refills

Two weeks prior to when you will need another 90-day supply of your medication, call us at 412-246-0963 to place your refill order.
Duquesne University Pharmacy Patient Enrollment Form

Phone: (412) 246-0963  
Physician Fax: 1-866-297-1512  
Address: 1860 Center Avenue  
Fax: (412) 246-2037  
(for new prescription)  
Pittsburgh, PA. 15219

* The enrollment form is only necessary for first-time orders, including your dependents or changing your current information.

* If you have questions, please contact the Duquesne University Pharmacy Patient Service Center at (412) 246-0963.

Please check here if you want easy-open caps

<table>
<thead>
<tr>
<th>Today's Date:</th>
<th>Date Needed and Any Special Instructions:</th>
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</table>

**PATIENT INFORMATION**

Name:

Address:  
City:  
State:  
Zip Code:

Home Phone:  
Work Phone:  
Cell Phone:

DOB:  
Allergies:

**INSURANCE INFORMATION:** Please provide information if available on your card

**PRIMARY INSURANCE:**

Patient’s ID #:  
Group #:  
Bin#:  

Cardholder’s Name (if not patient):

**SECONDARY INSURANCE:**

Patient’s ID #:  
Group #:  
Phone #:  

Cardholder’s Name (if not patient):

**PRESCRIPTION TRANSFER INFORMATION:** (we will contact your pharmacy or prescriber for your prescription)

Pharmacy Name:  
Prescriber’s Name:

Phone:  
Phone:  
Office Contact Name:

**PRESCRIPTION MEDICATION REQUESTED**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th>Directions</th>
<th>Quantity</th>
<th># of Refills</th>
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**Delivery Information:**

<table>
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<tr>
<th>Signature:</th>
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