Specialty Pharmacy Services Enrollment Form

Fax Referral To: 800-323-2445
Phone: 866-278-5108

Date: __________ **Needs by Date:** __________

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** ____________________

PATIENT INFORMATION

(Complete the following ***or send patient demographic sheet****)*

Patient Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone: ____________________
Alternate Phone: ____________________
Last Four of SS #: __________ Primary Language: __________
Date of Birth: __________ Gender: __________

PRESCRIBER INFORMATION

Prescriber's Name: ____________________
State License #: __________ UPIN: __________
DEA #: __________ NPI #: __________
Group or Hospital: ____________________
Address: ____________________
City, State Zip: ____________________
Phone: __________ Fax: __________
Contact Person: __________ Phone: __________

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card*)

Prescription Card: Name of Insurer: __________ ID#: __________ BIN: __________ PCN: __________ Group: __________
Primary Insurance: Subscriber: __________ ID#: __________ Name of Insurer: __________ Phone: __________
Secondary Insurance: Subscriber: __________ ID#: __________ Name of Insurer: __________ Phone: __________

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

Please include diagnosis name and ICD-9:

____
____
____
____

- Date of Diagnosis: __________

Additional Clinical Information: Therapy: ☐ New ☐ Reauthorization ☐ Restart

- Weight: __________ kg/lbs
- Height: __________ in/cm
- Allergies: ____________________
- Lab Data: ____________________
- Concomitant Medications: ____________________
- Additional Comments: ____________________

____

Injection Training/Home Health Coordination:

- Injection training/home health will be/has been conducted/coordinated by the Physician's office. ☐ Yes ☐ No
- If Yes, Date: _____
- Specialty Pharmacy to coordinate injection training/home health nursing. ☐ Yes ☐ No *Agency of Choice: __________

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐				
☐				
☐				
☐				
☐				
☐				
☐				

X ____________________
PRODUCT SUBSTITUTION PERMITTED

X ____________________
DISPENSE AS WRITTEN (Date)

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