



# 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

<b>Diagnosis:</b>	<b>Additional Clinical Information:</b>	Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart
Please include diagnosis name and ICD-9: _____ _____ _____ _____ • Date of Diagnosis: _____	<ul style="list-style-type: none"> <li>• Weight: _____ kg/lbs</li> <li>• Allergies: _____</li> <li>• Lab Data: _____</li> <li>• Concomitant Medications: _____</li> <li>• Additional Comments: _____</li> </ul>	• Height: _____ in/cm

**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
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

**PRODUCT SUBSTITUTION PERMITTED**

**DISPENSE AS WRITTEN** (Date) \_\_\_\_\_

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