



# Specialty Pharmacy Services Enrollment Form



Fax Referral To: 800-323-2445

Phone: 800-237-2767

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: \_\_\_\_\_  
SS #: \_\_\_\_\_  
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
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

**IMPORTANT NOTICE:** This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Specialty Pharmacy Services 092910