



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)*

Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis:	Additional Clinical Information:
Please include diagnosis name and ICD-9: _____ _____ _____ • Date of Diagnosis: _____	<ul style="list-style-type: none"> • 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

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 072108