



Fax Referral To: 800-323-2445

Phone: 800-237-2767

# Specialty Pharmacy Services Enrollment Form

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:

Please include diagnosis name and ICD-9:

#### Additional Clinical Information:

• Weight: \_\_\_\_\_ kg/lbs • Height: \_\_\_\_\_ in/cm  
• Allergies: \_\_\_\_\_  
• Lab Data: \_\_\_\_\_  
• Concomitant Medications: \_\_\_\_\_  
• Additional Comments: \_\_\_\_\_

• Date of Diagnosis: \_\_\_\_\_

#### 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)

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