

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: M F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY:

ICD-10: _____ Acute Chronic

Date of Diagnosis: _____ Contraindications: No Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Prior Failed Treatments:

Length of Treatment:

Prior Failed Treatments:	Length of Treatment:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If Prior Authorization is Denied:

Automatically Draft Appeal for Review Send Preferred Formulary Alternatives

4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
BEHAVIORAL HEALTH <input type="checkbox"/> Namenda® <input type="checkbox"/> Silenor® <input type="checkbox"/> Viibryd® <input type="checkbox"/> Namzaric®				
CARDIOLOGY <input type="checkbox"/> Eliquis® <input type="checkbox"/> Multaq® <input type="checkbox"/> Xarelto® <input type="checkbox"/> Entresto®				
DERMATOLOGY <input type="checkbox"/> Solodyn® <input type="checkbox"/> Zyclara®				
DIABETES MELLITUS <input type="checkbox"/> Farxiga® <input type="checkbox"/> Invokamet® XR <input type="checkbox"/> Janumet® <input type="checkbox"/> Invokamet® <input type="checkbox"/> Invokana® <input type="checkbox"/> Januvia®				
Irritable Bowel Syndrome Constipation / Other <input type="checkbox"/> Amitiza <input type="checkbox"/> Linzess® <input type="checkbox"/> Movantik®				

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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