Star Discount Pharmacy
specialty care

To Whom It May Concern:

I hereby authorize Star Discount Pharmacy, Inc. (hereinafter referred to as "Star") to act as my designee for initiating and coordinating insurance prior authorizations, appeals, nursing services and patient assistance program coordination for prescription orders it receives for my patients. I further authorize Star to use all means of communication, including without limitation fax, internet, e-mail, web-portals, electronic prior authorization services and telephonic methods as required or supported by third-parties, including the use of my caller ID information so that my number and name (or the name of my practice) is displayed when calling patients, insurance companies and other third-party payors or patient assistance providers.

By providing my e-mail below, I agree to receive requests for electronic signatures from Star. I will provide Star with all clinical information necessary to obtain prior authorization and patient assistance services for my patients. I understand that prior authorization approval and insurance benefits will be determined by the payor based upon each patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things, and that participation in this program is not a guarantee of prior authorization or of payment.

Upon request, Star will provide me with a copy of the information that was submitted by Star for prior authorization. This authorization form will be active for one (1) year or until I retire or leave the practice of medicine, whichever is sooner. In the event any prior authorization obtained under this agreement expires, I understand Star will make a reasonable effort to contact my office to ensure the affected patient is to continue treatment of the prescribed medication(s), and, if so, I understand Star will send me a new prior authorization form for my signature. I hereby authorize Star to coordinate any such prior authorization or patient assistance programs as set forth above.

Signature of Prescriber/ Nurse Practitioner /Agent _____ Date _____

NPI Number _____ Facility NPI _____

Phone Number _____/ Fax Number _____ Facility Phone Number _____ Facility Fax Number _____

Prescriber Email _____ Facility or Practice Email _____

Facility Name and Address _____ PTAN Number _____

Additional Prescribers Giving Authorization

Name	Signature	NPI Number	E-mail
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