



**Specialty Care**

Call: (877) 883-1392 Fax: (256) 429-2221

**Patient Information:** Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_ Caregiver: \_\_\_\_\_  
 Email: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Allergies:  No Known  See Attached Charts  Other: \_\_\_\_\_ Last 4 of SSN: \_\_\_\_\_

**Please include front and back copies of insurance card.**

**Prescriber Information:**

Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

**Statement of Medical Necessity (Please Attach All Medical Documentation)**

Date of Diagnosis: \_\_\_\_\_  Acute  Chronic  
 ICD-10: \_\_\_\_\_  
 Contraindications:  No  Yes \_\_\_\_\_

Prior Failed Treatments	Drug Name & Length of Treatment

**Injection Training:**  
 Pharmacist to Provide Training  
 Patient Trained in MD Office  
 Manufacturer Nurse Support

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

Test/Procedure	Date Performed	Results

**Product Delivery:**  
 Patient's Home  
 Physician's Office  
 Pharmacy to Coordinate

**Prescription Information**

Medication	Dosage & Strength	Directions	Qty	Refills

**Prescriber Signature** (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: \_\_\_\_\_ 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.

**Confidentiality Notice:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.