Star Discount Pharmacy
specialty care

Specialty Care **Close to Home™**

To Whom It May Concern,

I hereby authorize Star Discount Pharmacy or KloudScript, Inc. 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 understand that Star Discount Pharmacy will contract with a third-party, KloudScript, Inc. to assist with these services. I further authorize Star Discount Pharmacy or KloudScript, Inc. to use all means of communication including 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 Discount Pharmacy or KloudScript, Inc. I will provide Star Discount Pharmacy or KloudScript, Inc. with all clinical information that is necessary in order to obtain prior authorization and patient assistance services necessary 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 Discount Pharmacy or KloudScript, Inc. will provide me with a copy of the information that was submitted for prior authorization. This authorization form will be active for one (1) year or until I retire or leave the practice, whichever is sooner. In the event any prior authorization obtained under this agreement expires, I understand that Star Discount Pharmacy or KloudScript, Inc. will contact my office to ensure that the affected patient is to continue treatment of the prescribed medication(s), and, if so, I understand that Star Discount Pharmacy or KloudScript, Inc. will send me a new prior authorization form for my signature. I hereby authorize Star Discount Pharmacy or KloudScript, Inc. 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

Additional Prescribers Giving Authorization

Name	Signature	NPI Number	E-mail
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____