



Specialty Care

Call: (877) 883-1392 Fax: (256) 919-0000

			(533)	(200)			
Patient Information:	Name:		DOB:	Gender:	Ом О г		
Address:		С	itv:	State:	Zip:		
	Alt. Phone:						
Email:	Ait. Phone.		Caregiver		Moight:		
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Allergies. ONO KHOWH			oack copies of insurance	card			
		iront and b	ack copies of insurance	<u>caru.</u>			
Prescriber Information	:						
Name:		NPI:					
					State: Zip:		
			Office Contact:				
Statement of Medical I	Necessity (Please Attach All	Medical Do	ocumentation)				
Date of Diagnosis: Acute Chronic		c I	Prior Failed Treatmen	ts Drug Nan	Drug Name & Length of Treatment		
ICD-10:							
Contraindications: ONo	○Yes						
Injection Training:							
Pharmacist to Provide Tra	aining						
Patient Trained in MD Off	-	•					
Manufacturer Nurse Support			Diagnosis Procedure(s) or Laboratory Test(s)				
		i	_				
Product Delivery:			Test/Procedure	est/Procedure Date Performed		Results	
O Patient's Home							
OPhysician's Office							
O Pharmacy to Coordinate							
Prescription Information	on						
Medication	Dosage & Strength		Directions		Qty	Refills	
Prescriber Signa	iture (I authorize pharmacy t	to act as my d	esignee for initiating and coord	dinating incurance prior	r authorizations nur	sing services	
and patient assistance programs		to act as my a	esignee for initiating and coord	amating insurance prior	dathonzations, nar	Sing Sci vices	
Signature: Sign		Signati	uro:		Date:		
Substitution Permitted		_ Signati	Dispense as Written		Date		
Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical							
	of the patient's coverage, a	mong otne	r unings. Participation in	unis program is no	ı a guarantee of	prior	
authorization or of payme	ent.						

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