Star Discount Pharmacy specialty care

Specialty Care

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

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:

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 _____

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

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

Prior Failed Treatments	Drug Name & Length of Treatment

Diagnosis Procedure(s) or Laboratory Test(s)

Test/Procedure	Date Performed	Results

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.

Revised 10/15/2020