

REQUIRED: Demographics & Most recent H&P, Clinical Notes, and Medication List

PATIENT INFORMATION

Patient Name	Date of Birth	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address				
Home Phone	Work Phone	Cell Phone		

INSURANCE INFORMATION: Please fax a copy of the insurance card(s) with this form (front and back)

MEDICAL INFORMATION

Weight (kg)	Height	Allergies		
Diagnosis	ICD-10			
Patient Status	<input type="checkbox"/> New to Therapy	<input type="checkbox"/> Continuing Therapy	Next Treatment Date	
Line Access	<input type="checkbox"/> Port	<input type="checkbox"/> PICC	Other: _____	Lumens <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

PRESCRIPTION

Lab Orders _____ Frequency _____

PROVIDER INFORMATION

By signing this form and utilizing our services, the prescriber is authorizing *Pharmacy Specialists* and its employees to serve as their prior authorization and designated agent in dealing with medical and prescription insurance companies. The prescriber certifies that the use of the indicated treatment is medically necessary, and the prescriber will supervise the patient's treatment.

Prescriber Name	Signature	Date
Prescriber NPI	Phone	Fax
Contact Person		

REFERRAL AND INSURANCE APPROVAL PROCESS: Please submit a completed order form and all required documentation. *Pharmacy Specialists* will complete insurance verification and submit all required documentation to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. Financial responsibility will be reviewed with the patient. Any available co-pay assistance programs will be discussed with the patient as needed. Thank you for the referral.

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