Elite Specialty Pharmacy
Your Choice Above The Rest

SPECIALTY PHARMACY GENERAL REQUEST FORM

Fax Completed Form To: (877) 577-6447

Nzone-Elite Specialty Pharmacy
10210 101st Ave
Ozone Park, NY 11416
Phone: (718) 880-1783

Date **Ship to** ☐ **Patient** ☐ **Office** ☐ **Other**

PATIENT INFORMATION

(Complete the following *or send patient demographic sheet*)

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Patient SS#: _____
Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI: _____
Group or Hospital: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
Contact Person: _____

INSURANCE INFORMATION

Other Medications: Current Medication List _____
Dosage _____ Strength _____

Primary Insurance/ Prescription Card:	PLEASE FAX COPY OF INS CARD (FRONT & BACK)	Secondary Insurance/ Prescription Card:	PLEASE FAX COPY OF INS CARD (FRONT & BACK)

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

Please include diagnosis name and ICD-10

_____
_____
_____
_____

• Date of Diagnosis: _____

Additional Clinical Information: Therapy: ☐ New ☐ Reauthorization ☐ Restart

• Weight: _____ kg/lbs • Height: _____ in/cm
• Allergies: _____
• Lab Data: _____
• Concomitant Medications: _____
• Additional Comments: _____

Injection Training/Home Health Coordination:

• Injection training/home health will be/has been conducted/coordinated by the Physician's office. ☐ Yes ☐ No • If Yes, Date: _____
• Specialty Pharmacy to coordinate injection training/home health nursing. ☐ Yes ☐ No *Agency of Choice: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐				
☐				
☐				
☐				
☐				
☐				
☐				

Any known allergies? ☐ Yes ☐ No List: _____

_____
Prescriber Signature (Date)

Patient Will Accept Product Substitution/Generic Yes ☐ No ☐