



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
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Any known allergies? Yes No List: _____

_____ Prescriber Signature	_____ (Date)	Patient Will Accept Product Substitution/Generic	Yes	No
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