PROFESSIONAL PHARMACY GROUP
Specialty Pharmacy

To Whom It May Concern,

I hereby authorize Med-Park Pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, appeals, nursing services, and patient assistance program coordination for prescription orders it receives for my patients. I understand that Med-Park Pharmacy will contract with a third-party, Asembia LLC. to assist with these services. I further authorize Med-Park Pharmacy to use all means of communication including fax, internet, e-mail, web-portals, electronic prior authorization services, and telephonic methods as required or supported by third-parties, including the use of my caller ID information so that my number and name (or the name of my practice) is displayed when calling patients, insurance companies and other third-party payors or patient assistance providers. By providing my e-mail below, I agree to receive requests for electronic signatures from Med-Park Pharmacy I will provide Med-Park Pharmacy with all clinical information that is necessary to obtain prior authorization and patient assistance services necessary for my patients. I understand that prior authorization approval and insurance benefits will be determined by the payor based upon each patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things, and that participation in this program is not a guarantee of prior authorization or of payment. Upon request, Med-Park Pharmacy will provide me with a copy of the information that was submitted for prior authorization. This authorization form will be active for one (1) year or until I retire or leave the practice, whichever is sooner. In the event any prior authorization obtained under this agreement expires, I understand that Med-Park Pharmacy will contact my office to ensure that the affected patient is to continue treatment of the prescribed medication(s), and, if so, I understand that Med-Park Pharmacy will send me a new prior authorization form for my signature. I hereby authorize Med-Park Pharmacy to coordinate any such prior authorization or patient assistance programs as set forth above.

_____ _____

Signature of Prescriber/ Nurse Practitioner /Agent | Date

_____ _____

NPI Number | Facility NPI

_____/_____ _____/_____

Phone Number | Fax Number | Facility Phone Number | Facility Fax Number

_____ _____

Prescriber Email | Facility or Practice Email

_____

Facility Name and Address

Additional Prescribers Giving Authorization

Name	Signature	NPI Number	E-mail
_____	_____	_____	_____
_____	_____	_____	_____

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