PROFESSIONAL PHARMACY GROUP
Specialty Pharmacy

SPECIALTY CARE PROGRAM
Phone: 844-223-7510
Fax: 844-673-6161

1 PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____

DOB: _____ Gender: ❍ M ❍ F Caregiver: _____

Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ DEA: _____

Office Contact: _____ Phone: _____

Email: _____

3 STATEMENT OF MEDICAL NECESSITY:

ICD-10: _____ ❑ Acute ❑ Chronic

Date of Diagnosis: _____ Contraindications: ❑ No ❑ Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
1.		
2.		
3.		

If Prior Authorization is Denied:

❑ Automatically Draft Appeal for Review ❑ Send Preferred Formulary Alternatives

Prior Failed Treatments:	Length of Treatment:

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 REQUIRED INFORMATION: Front & back copies of pharmacy & medical cards along with charts & labs from last 90 days

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	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: _____ Date: _____ 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.