



An independent Licensee of the Blue Cross and Blue Shield Association

# Specialty Pharmacy Services Enrollment Form



Fax Referral To: 800-323-2445  
Phone: 866-278-5108

Date: \_\_\_\_\_ Needs by 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: \_\_\_\_\_  
Last Four of SS #: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

### PRESCRIBER INFORMATION

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

### INSURANCE INFORMATION (Please copy and attach the front and back of insurance and prescription drug card)

**Prescription Card:** Name of Insurer: \_\_\_\_\_ ID#: \_\_\_\_\_ ID#: \_\_\_\_\_ PCN: \_\_\_\_\_ Group: \_\_\_\_\_  
**Primary Insurance:** Subscriber: \_\_\_\_\_ ID#: \_\_\_\_\_ Name of Insurer: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Secondary Insurance:** Subscriber: \_\_\_\_\_ ID#: \_\_\_\_\_ Name of Insurer: \_\_\_\_\_ Phone: \_\_\_\_\_

### STATEMENT OF MEDICAL NECESSITY

**Diagnosis:** Please include diagnosis name and ICD-9: \_\_\_\_\_  
Date of Diagnosis: \_\_\_\_\_  
**Additional Clinical Information:** Therapy:  New  Reauthorization  Restart  
• Weight: \_\_\_\_\_ • 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"/>				

PRODUCT SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN (Date) \_\_\_\_\_

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