



Specialty Pharmacy Medication Request

Customer Service: 1-800-288-2078

Fax Order Submission: 1-312-416-2880

ALL RELEVANT INFORMATION MUST BE COMPLETED BELOW. ALLIED'S RECEIPT OF THIS COMPLETED FORM DOES NOT CONSTITUTE A GUARANTEE OF BENEFITS.

Today's Date	Date Needed
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SECTION A - PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: Zip:
Home Phone:		Work Phone:	Cell Phone:
DOB:	Height:	Weight:	Allergies:

Is this patient currently hospitalized? Yes No
 If **Yes**, please provide the following ship and bill authorization information before faxing in this form:
 Ship and Bill Authorization Contact Name: _____ Phone Number: _____
 If **No**, please completely fill out **Sections B, C, and D** before faxing in this form. **All required sections must be completed in full to ensure covered prescriptions ship within 24-48 hours.** If these sections are **not** completed accurately, your order may be delayed.

SECTION B - INSURANCE INFORMATION

Primary Insurance:		Pharmacy Benefit Manager (PBM):	
Policy #:	Group #:	Insured:	Phone:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide #:		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide #:	
Secondary Insurance:			
Policy #:	Group #:	Insured:	Phone:

SECTION C - PHYSICIAN INFORMATION

First Name:		Last Name:		M.D./D.O.	
Address:		City:	State:	Zip:	
Phone:	Fax:	St Lic. #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

SECTION D - CURRENT MEDICAL INFORMATION

Primary Diagnosis		ICD-9 Code	Secondary Diagnosis		ICD-9 Code
Medication	Strength	Directions		Quantity	# of Refills

Authorization Number (if required)	Shipping To: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Home Care Agency (name and address if available): _____ <input type="checkbox"/> Ambulatory Infusion Center (location address): _____
Administration Site: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Ambulatory Infusion Center	

Prescriber's Signature (Required by Law)

When submitting a prior authorization request, please note the following information is necessary when applying criteria and determining medical necessity:

- The member's current signs/ symptoms or chief complaint as well as the duration of symptoms.
- Medical history & Physical exams along with the MOST current physician's progress notes.
- 3-6 months clinical information.
- Current Medications as well as medications that have been TRIED/FAILED including any ESI, steroid/ hormone injections.
- Send any imaging studies such as U/S reports, x-rays, CT's, if applicable to request.
- Send any LAB WORK such as fecal occult blood tests/ culture reports/ Hematocrit/Hemaglobin/ Hormone studies/ TSHs.