Specialty Pharmacy Medical Request

Allied Benefit Systems, Inc.
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All relevant information must be completed below. Allied's receipt of this completed form does no constitute a guarantee of benefits.

Today's Date	Date Needed

SECTION A - PATIENT INFORMATION

Patient First Name	Patient Last Name		
Subscriber First Name	**Subscriber Last Name**		
Address	**City**	**State**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**	
DOB	**Height**	**Weight**	**Allergies**

Is this patient currently hospitalized? ☐ Yes ☐ No

Is this provider going buy & bill the medication? ☐ Yes ☐ No

If **yes**, please provide the following ship and bill authorization information before returning this form:

Ship and Bill Authorization Contact Name: _____ Phone Number _____

If **no**, please completely fill out **Sections B, C and D** before returning this form. **All required sections must be completed in full to ensure covered prescriptions ship within 3-7 business days**. If these sections are not completed accurately, your order may be delayed.

SECTION B - INSURANCE INFORMATION

Primary Insurance		Pharmacy Benefit Manager	
Policy #	**Group #**	**Insured**	**Phone**
Medicare?	**If yes, provide #**	**Medicaid?**	**If yes, provide #**
☐ Yes ☐ No		☐ Yes ☐ No	
Secondary Insurance		**Pharmacy Benefit Manager**	
Policy #	**Group #**	**Insured**	**Phone**

SECTION C - PHYSICIAN INFORMATION

First Name			Last Name		
Address			**City**	**State**	**Zip**
Phone	**Fax**	**St Lic #**	**NPI #**	**DEA #**	**UPIN**
Office Contact Name			**Phone**		

SECTION D - CURRENT MEDICAL INFORMATION

Primary Diagnosis	ICD-10 Code	Secondary Diagnosis	ICD-10 Code

Medication Name & HCPCS/CPT Code	Strength	Directions	Quantity	# of Refills

Authorization Number (if required)	

Administration Site

☐ Physician's Office ☐ Patient's Home ☐ Home Care Agency ☐ Ambulatory Infusion Center

Shipping To

☐ Physician's Office

☐ Patient's Home

☐ Home Care Agency (name and address if available)

☐ Ambulatory Infusion Center (location address)

Prescribers Signature (required by law) Date

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 complaints as well as the duration of the symptoms
- Medical history and 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 ESI, steroid/hormone injections
- Send any imaging studies such as U/S reports, x-rays, CTs, if applicable to request
- Send any LAB WORK such as fecal occult blood test / culture reports / Hematocrit / Hemoglobin / Hormone studies / TSHs
- Copy of the Rx Order or Script