# Allied Specialty Pharmacy Medication Request

**Customer Service: 1-800-288-2078** **Fax Order Submission:** 3122811636

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** |
|---|---|

## 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: ☐ Yes ☐ No If Yes, provide #: | | Medicaid: ☐ Yes ☐ 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)

**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): _____

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.