

Specialty Pharmacy Services Enrollment Form



Fax referral to: 617-806-8577 or Email: Pharmacy@challiance.org

Phone: 866-319-8257

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____
 Address: _____
 City, State, ZIP: _____

Preferred Contact Method: Phone Text Email
(to primary # provided below) (to cell # provided below) (to email provided below)
 Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Home Cell Work
 Alternate Phone: _____ Home Cell Work
 DOB: _____ Gender: Male Female
 Email: _____
 Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ NPI #: _____
 DEA #: _____

Group or Hospital: _____
 Address: _____
 City, State, ZIP: _____
 Phone: _____
 Fax: _____
 Contact Person: _____
 Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____
 Ship to: Patient Office Other: _____

Diagnosis (ICD-10):
 Code: _____ Description: _____ Code: _____ Description: _____
 Code: _____ Description: _____ Code: _____ Description: _____

Patient Clinical Information:
 Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm
 Concomitant Medications: _____
 Additional Comments: _____

Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary? Yes No
 Injection training is not necessary. Date training occurred: _____
 Reason: MD office training patient Pt already independent Referred by MD office to alternate trainer

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/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"/>				

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

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 Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.