Specialty Pharmacy Services Enrollment Form

CHA Cambridge Health Alliance

Fax referral to: 617-806-8577 or Email: Pharmacy@challiance.org
Phone: 866-319-8257

Six Simple Steps to Submitting a Referral

❶PATIENT 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: _____

❷ PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact's Phone: _____

❸INSURANCE INFORMATION

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

❹DIAGNOSIS 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

❺PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐				
☐				
☐				
☐				
☐				
☐				
☐				
☐				

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

❻X_____ X_____
PHYSICIAN SIGNATURE REQUIRED

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