Dotum Optum Specialty Phone: 855-427-4682 **General Enrollment Form** Optum Specialty Fax: 877-342-4596 Please detach before submitting to a pharmacy - tear here. Specialty Pharmacy Enrollment Form This form is not a valid prescription in Arizona or Virginia **PRESCRIBER INFORMATION** PATIENT INFORMATION Please complete the following or send patient demographic sheet Prescriber's Name Patient Name DEA _ Address NPT Address 2 . Group/Hospital_ City, State, ZIP Address Home Phone Alternate Phone City, State, ZIP _ DOB _ Last Four of SS# ___ _ Gender _ Phone Fax Language Preference: English Spanish Other Contact Person _ Phone _ **INSURANCE INFORMATION** (Must fax a copy of patient's insurance card including both sides) Prior Authorization Reference number MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed) Additional Information Diagnosis - Please include diagnosis name with ICD-10 code Therapy: New Reauthorization Restart Weight ____ _ kg/lbs Height _ . cm/in Allergies Lab Data Concomitant Medications Additional Comments. Date of Diagnosis Injection Training/Home Health Coordination: Injection training/home health will be/has been conducted by the physician's office: 🗌 Yes No No If Yes, Date _ Yes 🗌 No Specialty pharmacy to coordinate injection training/home health nursing: Agency of Choice . PRESCRIPTION INFORMATION Refills Medication Dose/Strength Directions Quantity Ship to: Office Other Date Needs by Date Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. Substitution permitted **Dispense as Written** Prescriber's Prescriber's Signature Date Signature Date Electronic or digital signatures not accepted. Electronic or digital signatures not accepted

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