Optum

Optum Specialty Phone: 855-427-4682
Optum Specialty Fax: 877-342-4596

General Enrollment Form

Specialty Pharmacy Enrollment Form ✂ Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona or Virginia**

PATIENT INFORMATION

Please complete the following or ***send patient demographic sheet***

Patient Name _____

Address _____

Address 2 _____

City, State, ZIP _____

Home Phone _____ Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____

NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

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)*

Diagnosis – Please include diagnosis name with ICD-10 code

_____

_____

_____

_____

_____

_____

Date of Diagnosis _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Concomitant Medications _____

_____

Additional Comments _____

_____

Injection Training/Home Health Coordination:

Injection training/home health will be/has been conducted by the physician's office: ☐ Yes ☐ No If Yes, Date _____

Specialty pharmacy to coordinate injection training/home health nursing: ☐ Yes ☐ No Agency of Choice _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills

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.

Dispense as Written

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.

Substitution permitted

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.