



**SPECIALTY MEDICATION ENROLLMENT FORM**  
(For specialty medication **NOT** requiring prior authorization)

**PATIENT INFORMATION**

**TODAY'S DATE:**

Patient Name (First)	Last	MI	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB
Patient Address		City	State	Zip
Home Phone	Work Phone	Best time to contact patient: <input type="checkbox"/> AM <input type="checkbox"/> PM		
Caregiver/Emergency Contact Name		Relationship	Phone	
Special Instructions (allergies, pregnant, etc.):				

**INSURANCE INFORMATION**

Policyholder Name	ID #	DOB
Employer	Group Number	Insurance Phone

**PHYSICIAN INFORMATION**

Physician Last Name	First Name	UPIN	DEA
Clinic Name	Office Contact	Phone	Fax
Physician Address	City	State	Zip

**PRESCRIPTION INFORMATION**

Date Needed	Quantity	Days Supply
Drug Name	Dose	
Generic Substitutions Allowed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis	
<p><b>All enrollment form information will be forwarded to the appropriate PrimeRxSpecialty network pharmacy provider. Upon review the selected pharmacy provider will contact the member and physician for complete patient and prescription information.</b></p>		

**DELIVERY INSTRUCTIONS**

<input type="checkbox"/> Home	<input type="checkbox"/> Physicians office	<input type="checkbox"/> Workplace	<input type="checkbox"/> Other
Address (if different from above)			
City	State	Zip	Phone

**Please fax or mail this form to:**  
Prime Therapeutics LLC  
Attn: RX Specialty Referral Center  
P.O. Box 2228  
Omaha, Nebraska 68103

**TOLL FREE**  
Fax: 888.891.3544  
Phone: 866.774.6079

**LOCAL**  
Fax: 402.970.2534  
Phone: 402.970.2533

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