PRIME THERAPEUTICS®

SPECIALTY MEDICATION ENROLLMENT FORM

PATIENT INFORMATION

DATE NEEDED:

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

INSURANCE INFORMATION

Pharmacy Provider:	**Prime Therapeutics**	Medical Plan Sponsor:			
Policy number:	Group number:	Person code:	Relationship:	BIN:	PCN:
Phone Number:		Prior Authorization needed?		☐ Yes	☐ No
Comments:		Authorization effective dates:			

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: ☐ Yes ☐ No	Diagnosis	

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.

DELIVERY INSTRUCTIONS

☐ Home ☐ Physicians office ☐ Workplace ☐ Other

Address (if different from above)

City State Zip Phone

Please fax this form to:
Prime Therapeutics LLC
Attn: PrimeRxSpecialty Referral Center

TOLL FREE
Fax: 888.891.3544
Phone: 866.774.6079

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