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 www.ochsnerspecialtypharmacy.com

**General**

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Male:  Female:   
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Tel: \_\_\_\_\_ Alt Tel: \_\_\_\_\_  
 SS#: \_\_\_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_\_\_  
 NKDA:  Allergy: \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Pharmacy Insurance \_\_\_\_\_  
 Member Name \_\_\_\_\_  
 Member ID: \_\_\_\_\_  
 Rx Group #: \_\_\_\_\_  
 BIN# \_\_\_\_\_ PCN# \_\_\_\_\_  
 Customer Service #: \_\_\_\_\_

**Please attach a copy of the front and back of the patient's insurance card, if available.\*\*\*\*\***

**DIAGNOSIS AND CLINICAL INFORMATION:**

Diagnosis and ICD10: \_\_\_\_\_  
 Prior meds failed: \_\_\_\_\_

**PRESCRIBER INFORMATION:**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 NPI#: \_\_\_\_\_ DEA #: \_\_\_\_\_ UPIN #: \_\_\_\_\_

By signing this form and using our services, you are authorizing Ochsner Specialty Pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.  
 Prescriber Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber Signature Below: *(Physician attests this is his/her legal signature. NO STAMPS)* \_\_\_\_\_

*Substitution Allowed*

*Dispense as Written*

**PRESCRIPTION:**

Medication	Strength	Directions	Quantity	Refills
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____