



SPECIALTY MEDICATION AUTHORIZATION FORM: URGENT ROUTINE REFERRAL

To Be Completed By Physician's Office and Faxed To Express-Scripts at 800-357-9577
Supporting medical records and documentation such as chart notes, lab results and completing this form are required for processing your request. Incomplete information will result in a delay in processing your request. The information must be faxed to the number above within 3 business days or your request will be denied.

Form with fields: Last Name, First Name, Home Phone Number, Today's Date, Date Needed, Parent / Guardian, Physician's Name (please print), Hospital / Clinic, Home Address, City, State, Zip, Address, City, State, Zip, Shipping Address, Phone Number, Fax Number, Office Contact.

Primary Insurance Company: Schaller Anderson - ESI/CHW (DIV : BFE), Member ID #, Date of Birth, Male/Female checkboxes.

Medication, Strength, Quantity, Refill, Direction for Use, Patient Ht., Patient Wt., Allergies, DEA/NPI, Physicians Signature.

Primary Diagnosis, ICD 9 Code, CPT Code, Estimated Start of Therapy, Facility Name, Medical History.

Empty box for additional information or notes.

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS