Sunray Specialty Pharmacy

OB/GYN Enrollment Form

Fax: (215) 471-4001
Phone: (215) 471-4000

PATIENT INFORMATION:

Patient's Name: ____
Address: ____
City, State, Zip Code: ____________________________________
Home Phone: _________________________
Alternate Phone: ______________________
DOB: ________________
Last 4 Digits of SS#: ________________
Gender: ________________
Language Preference: ____________________

PRESCRIBER INFORMATION:

Prescriber's Name: ____
DEA: ________________________
NPI: _________________________
Address: ____
City, State, Zip Code: ____
Phone: _______________________
Fax: ________________________
Contact Person: ____
Contact Person's Phone: ________________________

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

Prior Authorization Reference #: __________________

MEDICAL INFORMATION: (may attach separate sheet if needed)

Diagnosis: Please include diagnosis **and** ICD-10 code

ICD-10 Code: ________________
Description: _________________________

Additional information:

Therapy: ☐ New ☐ Reauthorization ☐ Restart
Weight: __________ kg/lb Height __________ cm/in
Allergies: ____
Lab Data: ____
Prior Therapies: ____
Concomitant Medications: ____
Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
Makena®	☐ 250mg/mL 1mL SDV ☐ 250mg/mL MDV			
RhoGAM®	☐ 300mcg			
Medroxyprogesterone	☐ 10mg tablet ☐ 150mg/mL PFS			
Lupaneta®	☐ 11.25-5mg kit ☐ 3.75-5mg kit			
Lupron-Depot®	☐ 3.75mg 1 month ☐ 11.25mg 3 months ☐ 7.5mg 1 month ☐ 22.5 mg 3 months ☐ 30mg 4 months ☐ 45mg 6 months			
Lupron Depot-Ped®	☐ 7.5mg ☐ 11.25mg ☐ 11.25 mg 3 months ☐ 30mg 3 months			
Orilissa™	☐ 150mg ☐ 200mg	☐ 150mg: Take 1 tablet by mouth daily ☐ 200mg: Take 1 tablet by mouth twice daily		
OTHER: ______________________________________				

Please deliver to: ☐ Patient ☐ Office ☐ Other _____________ by this date: ____________

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. 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.

☐ Product Substitution Permitted ☐ Dispense as Written

Prescriber's Signature: ___________________________________

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