



# Sunray

## Specialty Pharmacy

“Your Philadelphia Specialty Pharmacy”  
 142 S. 52<sup>nd</sup> St. Ste. 201  
 Philadelphia, PA 19139  
 Phone: (215) 471-4000 Fax: (215) 471-4001

### Hospital Enrollment Form

PATIENT INFORMATION:		PRESCRIBER INFORMATION:		
Patient's Name: _____		Prescriber's Name: _____		
Street Address: _____		DEA: _____		
Zip Code: _____		NPI: _____		
Home Phone: _____		Address: _____		
Alternate Phone: _____		Zip Code: _____		
DOB: _____		Phone: _____		
Last 4 Digits of SS#: _____		Contact Person: _____		
Gender: _____		Contact Person's Phone: _____		
Language Preference: _____		Contact Person's Email: _____		
PRESCRIPTION INFORMATION:				
Medication	Dose	Directions	Quantity	Refills
Abilify Maintena®				
Aristada®				
Invega Sustenna®				
Perseris™				
Prolixin®				
Risperdal®Consta®				
Vivitrol®				
OTHER: _____				
Please deliver to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Closest Sunray Drugs Injection Site to Patient <input type="checkbox"/> Other _____				
by this date: _____				
<p>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.</p> <p><input type="checkbox"/> Product Substitution Permitted <input type="checkbox"/> Dispense as Written</p>				
Prescriber's Signature: _____				
<p>CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.</p>				

**Please fax to Sunray Specialty Pharmacy at (215) 471-4001.**