REQUEST FOR PHARMACY PRIOR AUTHORIZATION AND MEDICATION APPROVAL SUPPORT SERVICES

Comprehensive Pharmacy Services Patient Care Service Center would like to offer your office and providers the ability to use our medication support services. These services will benefit our mutual patients by allowing the pharmacy to assist in Prior Authorization and Patient Assistance approval on behalf of the office.

Physician Information

Prescriber Name:_____ NPI #: _____

Contact:_____ Email: _____

Street:_____ City:_____ State:_____ Zip: _____

Phone:_____ Fax:_____ Tax ID # (needed for funding):_____

PA Contact Information

Primary PA Contact:_____ Title:_____

Email:_____ Phone:_____ Fax:_____

Preferred method of Contact: Email: ☐ Phone: ☐ Fax: ☐ IM: ☐

Additional Information

Does the physician practice out of multiple Locations? Yes ☐ No ☐

If yes, are Prior Authorizations handled centrally or by location?_____

Do you currently use any electronic platform for submission of Prior Authorizations? Yes No

If yes, please select the electronic platform used for submission of Prior Authorizations.

☐ CoverMyMeds ☐ Other ***If Other***, please list: _____

Prescriber Authorization Required to allow pharmacy to assist in prior authorization and medication access process

Comprehensive Pharmacy Services Patient Care Service Center ("CPS PCS") will assist with medication access for all patients who receive their specialty medication through Munson Specialty Pharmacy. This includes prior authorization completion and submission whenever applicable and also full completion of medication access programs including but not limited to copay assistance, foundation support, and free drug applications. CPS PCS cannot produce clinical information that was not already determined by the prescriber and either committed to the electronic chart, received by CPS PCS from the provider by other means, or by provider's clinical/administrative staff. CPS PCS will communicate and work with provider and/or provider's staff to obtain approval for medications sent to CPS PCS. Signature of this document does not expire unless written revocation by prescriber is received by the pharmacy. Upon leaving Munson Healthcare any providers previously enrolled in this supportive service will lose access and this agreement becomes void.

I hereby acknowledge these terms and conditions and authorize CPS PCS, its pharmacist and/or other representatives to assist in the initiation and submission of a prior authorization and/or other supportive medication access services.

Prescriber Name:_____ Date: _____

Signature (Required): _____ Date: _____