# Medication Request

**Aetna Specialty Pharmacy ®**
503 Sunport Lane
Orlando, FL 32809

**Customer Service: 1-866-782-2779 (1-866-782-ASRX)** **Fax Order Submission: 1-866-329-2779 (1-866-FAX-ASRX)**

UPON RECEIPT OF THIS FORM, AETNA SPECIALTY PHARMACY WILL VERIFY BENEFITS AND CONTACT MEMBERS BY TELEPHONE TO CONFIRM DELIVERY OF COVERED PRESCRIPTIONS. IT IS ESSENTIAL THAT AN AETNA SPECIALTY PHARMACY REPRESENTATIVE MAKE CONTACT WITH THE MEMBER IN ORDER TO ENSURE DELIVERY TO THE PATIENT'S HOME, PHYSICIAN'S OFFICE, OR AMBULATORY INFUSION CENTER WITHIN 24-48 HOURS.

| **Today's Date** | **Date Needed** |
|---|---|
| | |

## SECTION A - PATIENT INFORMATION

| First Name: | Last Name: | | |
|---|---|---|---|
| Address: | City: | State: | Zip: |
| Home Phone: | Work Phone: | Cell Phone: | |

| DOB: | Height: | Weight: | Allergies: |
|---|---|---|---|
| | | | |

Is this patient currently hospitalized? ☐ Yes ☐ No

If **Yes**, please provide the following ship and bill authorization information before faxing in this form:
Ship and Bill Authorization Contact Name: _____ Phone Number: _____

If **No**, please completely fill out **Sections B, C, and D** before faxing in this form. **All required sections must be completed in full to ensure covered prescriptions ship within 24-48 hours.** If these sections are **not** completed accurately, your order may be delayed.

## SECTION B - INSURANCE INFORMATION

| **Primary** Insurance: | | **Pharmacy Benefit Manager (PBM)**: | |
|---|---|---|---|
| Policy #: | Group #: | Insured: | Phone: |
| Medicare:<br>☐ Yes ☐ No If Yes, provide #: | | Medicaid:<br>☐ Yes ☐ No If Yes, provide #: | |

| **Secondary** Insurance: | | | |
|---|---|---|---|
| Policy #: | Group #: | Insured: | Phone: |

## SECTION C - PHYSICIAN INFORMATION

| First Name: | Last Name: | | M.D./D.O. |
|---|---|---|---|
| Address: | City: | State: | Zip: |

| Phone: | Fax: | St Lic. #: | NPI #: | DEA #: | UPIN: |
|---|---|---|---|---|---|
| | | | | | |

| Office Contact Name: | Phone: |
|---|---|
| | |

## SECTION D - MEDICAL INFORMATION

| **Primary** Diagnosis | ICD-9 Code | **Secondary** Diagnosis | ICD-9 Code |
|---|---|---|---|
| | | | |

| **Medication** | **Strength** | **Directions** | **Quantity** | **# of Refills** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Authorization Number** (if required)

**Administration Site:**
☐ Physician's Office ☐ Patient's Home
☐ Home Care Agency ☐ Ambulatory Infusion Center

**Shipping To**:
☐ Physician's Office ☐ Patient's Home
☐ Home Care Agency (name and address if available):
_____
☐ Ambulatory Infusion Center (location address):
_____

Prescriber's Signature **(Required by Law)**

Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through mail order. The charges Aetna negotiates with Aetna Specialty Pharmacy may be higher than the cost it pays for the drugs and the costs of its specialty pharmacy services. For these purposes, Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts it may receive from wholesalers, manufacturers, suppliers, and distributors.



**Please save this blank template and reproduce as necessary.**