



Neighborhood Health Plan

Specialty Pharmacy Prescription Order Form

Phone 1.866.591.9075 Fax: 1.866.591.9094



Patient Information

| | | | | | | | |
|------------------------|------------|--------------------------|--------------------------|---------------------------------|---------------|-------|-----|
| Last Name | First Name | Home Phone Number () | Work Phone Number () | Today's Date | Need Date | | |
| Parent / Guardian | | | | Physician's Name (please print) | Practice Name | | |
| Home Address | | | | Address | City | State | Zip |
| City | | State | Zip | Phone Number | Fax Number | | |
| Social Security Number | | Date of Birth | | Office Contact | | | |

Physician Information

Insurance Information

| | | | | | | |
|--|---------------------|-----------------|-----|---------------|-----------|--------------|
| Primary Insurance Company Neighborhood Health Plan | Phone Number () | Name of Insured | SSN | Employer Name | ID Number | Group Number |
| Secondary / Supplemental Insurance Co | Phone Number () | Name of Insured | SSN | Employer Name | ID Number | Group Number |

Special Instructions

| | |
|---|--|
| Special Instructions (Non-English Speaking Patients, etc.) | Instruction: <input type="checkbox"/> Self-Injected <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Home Health Agency |
| Patient's Current Weight _____ Allergies _____ | |
| Delivery Instructions: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Physician Office <input type="checkbox"/> Other _____ Shipping Address (If different from above) | |
| Statement of Medical Necessity : Primary Diagnosis: _____ ICD 9 Code _____ Other Treatments Tried and Failed: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list _____ | |

Medications

| | |
|---|---|
| Medication: _____ | Medication: _____ |
| Direction of Use: _____ | Direction of Use: _____ |
| Quantity: _____ Refill x _____ month(s) | Quantity: _____ Refill x _____ month(s) |

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS

Physician's Signature: _____ UPIN # / DEA _____

GENERIC SUBSTITUTION REQUIRED UNLESS THE PRACTITIONER WRITES NO SUBSTITUTIONS

Neighborhood Health Plan Specialty Pharmacy Program

Accredo Phone 1.866.591.9075
Accredo Fax 1.866.591.9094



Accredo Health is a specialty pharmacy provider contracted with Neighborhood Health Plan to provide selected specialty medications to Neighborhood Health Plan members and providers.

MEDICATIONS TO BE OBTAINED THROUGH ACCREDO

| | | | |
|-----------------|---------------|---------------|-----------------------|
| Advate | Flebogamma | Koate-DVI | Polygam S/D |
| Actimmune | Flolan | Kogenate FS | Profilinine SD |
| Albumin | Gammagard S/D | Monarc-M | Proplex T |
| Alphanate | Gammar-P | Monoclate P | Recombinat |
| Alphanine SD/VF | Gamunex | Mononine | Refacto |
| Bebulin VH | Helixate FS | NovoSeven | Remodulin |
| BeneFix | Hemofil-M | Octagam | Rhogam** |
| Carimune NF | Humate-P | Orfadin | Synagis ^{PA} |
| FEIBA VH | Iveegam | Pangoglobulin | Tracleer |
| | | | Xolair ^{PA} |

PA – Prior Authorization Required

** - Rhogam is available in limited quantities. To order, please call Accredo at 800.343.9813 or fax to 508.460.9876.

HOW TO ORDER SPECIALTY MEDICATIONS THROUGH ACCREDO HEALTH

Ordering Procedure

1. Physician's office contacts Accredo Health by telephone at 866-591-9075 or by completing and faxing the reverse side of this form to 866-591-9094*.
2. If the medication requires prior authorization, Accredo Health will obtain the critical information and contact Neighborhood Health Plan for the approval to dispense and bill
3. Upon verification of eligibility, the medication and accompanying supplies will be shipped to the requested location (physician or patient) within the requested timeframe so that therapy can begin or continue as needed.

*Only the physician's office can fax the prescription

Patient Counseling Services

Before dispensing a new prescription, an Accredo Health pharmacist will discuss the medication therapy with the patient, if appropriate.

Medication & Supply Delivery

- Based on the date needed, all medications will be shipped as soon as the next day to the physician's office or the patient's home, office or other United States destination.
- Medications will be shipped with all required supplies (needles, syringes and sharps kits) at no additional charge
- Medications requiring a nurse will be coordinated with the patient and/or home care agency to ensure that the necessary medication arrives in time for the nurse's arrival to the patient's home