



**BlueCross BlueShield  
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association.

This form should be completed by physician and staff.

# Specialty Pharmacy Form

Preferred Medical Doctor Customer Service  
1 877 231-7239

## Patient Information

Contract Number		Group Number	
Last Name	First Name	Middle Initial	
Cardholders Last Name	First Name	Middle Initial	
Street Address	City	State	Zip Code
Day Telephone (+Area Code)		Night Telephone (+Area Code)	
Date of Birth		Social Security Number	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Patient Weight: _____ kg. or _____ lbs.		
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____			

## Physician Information

PMD Prescriber's Name	Hospital/Clinic	Office Contact	
Address	City	State	Zip Code
Telephone Number (+area code)		Fax Number (+area code)	
Prescriber's License Number		DEA Number	
Is Physician PMD? <input type="checkbox"/> Yes <input type="checkbox"/> No			
UPIN		Provider Number	

## Statement of Medical Necessity

PRIMARY DIAGNOSIS (ICD-9 CM Code Plus Description) \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

## Rx

Drug Name	Dose	Quantity/Day Supply	SIG/Directions	Refills

Ancillary supplies as needed for injection.

Enroll patient in manufacturer support program

Dispense As Written  Substitution Allowed

Other Prescriber's Notes:

Ship to:  Patient  Doctor's Office

Prescriber's Signature \_\_\_\_\_

Date \_\_\_\_\_