

TADLIQ® PRESCRIPTION REQUEST FORM DIRECT TO SPECIALTY PHARMACY

Accredo Health Group, Inc. Fax: 888-686-1035 Tel: 866-344-4874

CVS Specialty Fax: 877-943-1000 Tel: 877-242-2738

Please complete and fax to the specialty pharmacy of your choice:

Optum Specialty Pharmacy

Fax: 877-342-4596 Tel: 855-427-4682

Other: _ PATIENT INFORMATION First Name: Last Name: Gender: DOB: (dd/mm/yyyy) Preferred Language: Male Female Street Address: City: State: ZIP: Home Phone: Cell Phone: Email: Authorized Caregiver or Alternate Contact: Relationship to Patient: Alternate Contact Phone: Alternate Contact Email: **INSURANCE INFORMATION** Patient has **NO** insurance Fax a copy of front and back of patient's medical and prescription benefit insurance cards or please complete the information below. Medical/Health Insurance Name: Phone: Policy ID: Group Number: Policy Holder Name: Policy Holder DOB: Relationship to Patient: Prescription Benefit Name: Phone: Group #: PCN #: BIN #: Policy ID: Policy Holder Name: Relationship to Patient: Policy Holder DOB: Phone: Secondary Benefit Insurance Name: Group Number:

Secondary Insurance Policy Holder Name:

Relationship to Patient:

Secondary Policy Holder DOB:

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