



TADLIQ® PRESCRIPTION REQUEST FORM DIRECT TO SPECIALTY PHARMACY

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

Accredo Health Group, Inc.

Fax: 888-686-1035

Tel: 866-344-4874

Other: _____

CVS Specialty

Fax: 877-943-1000

Tel: 877-242-273

Optum Specialty Pharmacy

Fax: 877-342-4596

Tel: 855-427-4682

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:	
Policy ID:	Group #:	PCN #:	BIN #:
Policy Holder Name:			
Policy Holder DOB:		Relationship to Patient:	
Secondary Benefit Insurance Name:		Phone:	
Group Number:			
Secondary Insurance Policy Holder Name:			
Secondary Policy Holder DOB:		Relationship to Patient:	

PRESCRIBER INFORMATION

Prescriber Name:		
Prescriber Specialty:		
Practice Name:		
Prescriber Email:		
Street Address:		
City:		State: ZIP:
Office Phone:		Office Fax:
MD NPI #:	Tax ID:	State License #:
Office Contact Name:		
Office Contact Phone:		
Office Contact Email:		

DIAGNOSIS

Patient Diagnosis (ICD-10):

PRESCRIPTION INFORMATION & AUTHORIZATION

	Dose:	Quantity:	NDC #:	Refills:
Tadliq 20mg/5mL			46287-045-15	
Directions for Use:				

I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direction and I have discussed with my patient and informed him/her of the Program enrollment. The information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to me by the dispensing pharmacy.

By signing below I certify that I am prescribing the TADLIQ medication for the patient identified in the Patient Information section. I certify that this prescription is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising the patient's treatment and verify that the information provided is complete and accurate to the best of my knowledge.

Prescriber Signature:	Date:
<div style="border: 1px solid red; height: 30px; width: 100%;"></div>	<div style="border: 1px solid red; height: 30px; width: 100%;"></div>

Dispense as Written/Do Not Substitute

Prescriber Signature:	OR	Date:
<div style="border: 1px solid teal; height: 30px; width: 100%;"></div>		<div style="border: 1px solid teal; height: 30px; width: 100%;"></div>

Substitution Permitted