

**SPECIALTY MEDICATION AUTHORIZATION FORM:**    URGENT     ROUTINE REFERRAL

**To Be Completed By Physician's Office and Faxed To Integral Quality Care (MFL) at 1-877-757-7964**

**Supporting medical records and documentation such as chart notes, lab results and completing this form are required for processing your request. Incomplete information will result in a delay in processing your request. The information must be faxed to the number above within 3 business days or your request will be denied.**

Last Name	First Name	Home Phone Number (   )	Today's Date	Date Needed
Parent / Guardian			Physician's Name (please print)	Hospital / Clinic
Home Address	City	State	Zip	Address
Shipping Address : Home <input type="checkbox"/> Work <input type="checkbox"/> Other <input type="checkbox"/> (If address is different from home – please provide below)			Phone Number (   )	Fax Number (   )
			Office Contact:	
			Referring PCP:	

Primary Insurance Company <b>Schaller Anderson - ESI/Integral Quality Care (DIV MFL)</b> <b>MFL Fax #: 1-877-757-7964</b>	Member ID #	Date of Birth	<input type="checkbox"/> Male or <input type="checkbox"/> Female
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Medication: _____	Strength: _____	Quantity: _____	Refill x _____ month(s)
Direction for Use: _____	Patient Ht. _____	Patient Wt. _____	Allergies: _____
Physicians Signature _____			UPIN # / DEA: _____

Primary Diagnosis: _____	ICD 9 Code: _____	CPT Code: _____	Estimated Start of Therapy: _____	Facility Name: _____
Medical History:				

<p><b><u>To Be Completed By Schaller Anderson and Faxed to Specialty Pharmacy for Processing:</u></b></p> <p><input type="checkbox"/> Authorization Approved and Override Entered</p>
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**PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS**

Disclaimer: This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you received this communication in error, please notify the sender at the phone number above. NOTICE TO RECIPIENT(S) OF INFORMATION: Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient..