877.389.9040 610.537.3212
www.ascellahealth.com

AscellaHealth Specialty Drug Order Form

Please complete one form per drug. Once completed, please fax this form to AscellaHealth at ***610-537-3212***.

Patient Information	Provider Information
Patient Name:	Provider Name:
Date of Birth: Sex: ☐M ☐F	Specialty
Street Address:	NPI: DEA:
City: State: ZIP:	Street Address:
Phone:	City: State: ZIP:
E-mail:	Office Contact:
Caregiver:	Phone: Fax:
Patient Insurance Information (Please send a copy of the patient's insurance card)	
Primary Insurance	**Secondary Insurance**
Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other	Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Plan Name:	Plan Name:
Plan Telephone #:	Plan Telephone #:
Patient ID Number:	Patient ID Number:
Patient Group #:	Patient Group #:
Patient Clinical Information (Please fax recent clinical notes, labs, and tests)	
Diagnosis: ICD 10:	Height: Weight: ☐lb ☐kg
Allergies:	
Current Medications:	
Prescription	
First Fill: ☐Yes ☐No If no, Last Filled Date:	Ship to: ☐Patient's Home ☐Physician's Office
Medication:	Dose/Strength:
Sig:	
QTY:	Refills:
Prescriber Signature:	
______________________ Dispense as Written ________ Date	______________________ Substitution Permissible ________ Date
To be Completed by Payer: Prior Authorization - Approval *Authorization Guarantees Payment*	
CNA Authorization #:	Authorization Date Range:
J-Code:	NDC #
Patient Out of Pocket (co-pay, deductible, co-insurance): $	
Approved By:	Date Approved:

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