AUTHORIZATION FOR PHARMACY PRIOR AUTHORIZATION AND MEDICATION APPROVAL SUPPORT SERVICES

Provider Information

Provider Name: _____ NPI#: _____

Office Contact: _____ Email: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Prior Authorization Contact Information (If Applicable)

Primary PA Contact: _____ Title: _____

Email: _____

Phone: _____ Fax: _____

**Preferred method of contact (please circle one): Email Phone Fax IM/Epic chat*

Provider Authorization

Note that this is required to allow pharmacy to assist in prior authorization and medication access process.

LCMC Health Pharmacy Services will assist with the medication access for all patients who receive their specialty medications through LCMC HEALTH PHARMACY SERVICES. This includes prior authorization completion and submission whenever applicable and full completion of specialty medication access programs including copay assistance, foundation support, and free drug applications. LCMC HEALTH PHARMACY SERVICES cannot produce clinical information that was not already determined by the prescriber and either committed to the electronic chart, received by LCMC HEALTH PHARMACY SERVICES from the provider by other means, i.e., by provider's clinical/administrative staff. LCMC HEALTH PHARMACY SERVICES will communicate and work with provider and/or provider's staff to obtain approval for specialty medications sent to LCMC HEALTH PHARMACY SERVICES. Prescriber's signature on this document does not expire unless written revocation by prescriber is received by the pharmacy. Upon leaving LCMC Health any providers previously enrolled in this supportive service will lose access and this agreement becomes void.

I hereby acknowledge these terms and conditions and authorize LCMC HEALTH PHARMACY SERVICES, its pharmacists and/or other representatives to assist in the initiation and submission of prior authorization and/or other supportive medication services.

Provider Signature: _____Date: _____