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 prior authorization contact_____ Title_____

Email _____

Phone_____ Fax_____

Preferred method of contact ◯ 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 medication access for all patients who receive their **specialty medications** through LCMC Health Specialty Pharmacy. 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 Heath 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 providers' 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 provider previously enrolled in this supportive service will lose access and this agreement becomes void.

I hereby acknowledge these terms and conditions and authorized LCMC Health Pharmacy Services, its pharmacists and/or other representations to assist in the initiation and submission of prior authorization and/or other supportive medication services.

/s/ Provider signature_____ Date_____

Your typed name serves as your signature.

LCMC Health