OPTUM®

GENERAL REFILL SHIPMENT REQUEST

Please complete for all patient refills and return with any pertinent patient information.

Fax: 866-926-0463 Phone: 877-409-9347

PATIENT INFORMATION	
Name:	Date of birth (mm/dd/yyyy):

REFILL INFORMATION

Date of next injection:

Drug name:_____

Date of next requested delivery (delivery LIMITED to Tuesday–Friday):
* Urgent turn around necessary, please call pharmacy

Patient/guardian/caregiver provides consent/authorization to ship medication to physician? ___Yes ___No

Please send my next shipment to the Provider shipping address listed below. I authorize Optum® Specialty Pharmacy to bill my insurance company for the shipment and that I am financially responsible for any copay/coinsurance and amounts not covered by my insurance that is associated with these shipments. I understand that either myself, or an authorized representative will need to contact Optum Specialty Pharmacy indicated above should circumstances change and I no longer need this next shipment.

Patient/guardian/caregiver signature: X _____

PROVIDER INFORMATION

Office contact:

Deliver to address:

Office Hours:

If there has been a change in insurance, please include copies of both sides of card.

If there are changes to the patients next refill please fax new prescription to

Fax: 866-926-0463

If you wish to discontinue treatment/shipments for this patient, please call the pharmacy at

Phone: 855-427-4682

OPT9311_191023