



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 | |

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