RegenceRx PHARMACY BENEFIT MANAGEMENT

McKESSON Empowering Healthcare

McKesson Specialty Pharmacy Enrollment Form

Fax completed form to: 1.888.591-8482
For customer service call: 1.888.456.7274

Plan Information

Select Plan: ❑ Regence Life and Health ❑ Regence BlueShield of Idaho ❑ Regence BlueCross BlueShield of Oregon
❑ RegenceRx ❑ Asuris Northwest Health ❑ Regence BlueShield (Washington) ❑ Regence BlueCross BlueShield of Utah

Patient Information

First Name: ______________ Last Name: ______________ M.I.: ______

Address: ______________ City/State: ______________ Zip: ______

Shipping Address (if different): ______________________________

Shipping Instructions: ______________________________

Patient I.D.: ______________ Date of Birth: ______________ Sex: ❑ M ❑ F

Phone: (______) ______________ Other Phone: (______) ______________

Primary language: ______________ Best time to contact Patient: ❑ Morning ❑ Evening

Provider Information

Last Name: ______________ First Name: ______________ Degree: ______

Clinic/Hospital: ______________ Contact: ______________

Address: ______________ City/State: ______________ Zip: ______

❑ Ship to MD Phone: (______) ______________ Fax: (______) ______________

DEA #: ______________ State License #: ______________ State Medicaid #: ______________

Statement of Medical Necessity

Patient Diagnosis: ______________________ ICD-9 Code: ______________

Is patient already on this medication? ______________ Approximate start date: ______________

Medical Rationale: ______________________________

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Please list which medications the patient has tried for this diagnosis (include chart notes if possible):

Medication Name	Dosage	Date(s) of Therapy	Outcome

Other medication(s) patient is taking: ______________________________

Patient height: ______________ Patient weight: ______________

Prescription

Medication Name: ______________ Date: ______________ Date Needed: ______________

Quantity: __________ Strength: __________ Refills: __________ Allergies: ______________

Directions: ______________________________

______________________________ ______________________________
Substitution Permitted (Signature) Dispense As Written (Signature)

PHYSICIAN SIGNATURE & DEA # REQUIRED TO VALIDATE PRESCRIPTIONS

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