



Specialty Pharmacy and Infusion Services

### Enrollment Form for OptionCare Specialty Pharmacy

How to place your initial order with OptionCare Specialty Pharmacy

- 1) Print and complete the Enrollment Form. Please print clearly.
- 2) Attach ORIGINAL prescription provided by your physician *or* ask your physician to fax the prescription to OptionCare Specialty Pharmacy at 1.888.570.4700.
- 3) Mail Enrollment Form and ORIGINAL prescription to OptionCare Specialty Pharmacy, 1350 Highland Drive, Suite D, Ann Arbor, Michigan 48108.

If you have questions or concerns, please call the OptionCare Customer Care Team toll free at 1.888.282.5166. Our hours are Monday through Saturday, 8:00 a.m. to 8:00 p.m.; Sunday, 8:00 a.m. to 1:00 p.m. Eastern Standard Time.

### Step 1: Demographic Information

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Delivery Address \_\_\_\_\_  
 \_\_\_\_\_  
 Day Phone Number w/area code \_\_\_\_\_ Evening Phone Number w/area code \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone Number w/area code \_\_\_\_\_  
 Check one  Original Prescription Enclosed  Physician Will Fax Prescription

### Step 2: Delivery Information

Requested Date of Delivery \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (You will be contacted by OptionCare if the delivery date cannot be accommodated.  
 Deliveries are available Tuesdays thru Fridays)  
 Medication(s) Requested  
 \_\_\_\_\_  
 \_\_\_\_\_

Supplies Needed\*  No  Yes If yes, please circle supplies needed:  
 Alcohol Wipes    Sharps Container    Pen Needles    Injection Syringes    Mixing Syringes    Inject-Ease

\*Please note: OptionCare provides standard supplies as a courtesy and cannot accommodate special requests. The quantity of supplies sent is based on the days supply of medication dispensed.

### Step 3: Payment Information

1) **Paying by Credit Card** (circle one)    Visa    MC    Discover    AMEX  
 Credit Card # \_\_\_\_\_ Exp Date \_\_\_\_ / \_\_\_\_  
 Security Code \_\_\_\_\_ (3 digits on back of card for Visa and 4 digits on front of card for AMEX)  
 Cardholder's signature \_\_\_\_\_

\_\_\_\_\_ Check here to authorize OptionCare to bill and debit your credit card for future orders. Call OptionCare at 1.866.515.1355 to set up auto-pay by phone.

2) **Paying by Check via Phone** (circle one)    Checking    Savings  
 \_\_\_\_\_ Account Number    \_\_\_\_\_ Routing Number  
 \_\_\_\_\_ Signature    \_\_\_\_\_ Name of Financial Institution

\_\_\_\_\_ Check here to authorize OptionCare to bill your checking/savings account for future orders. Call OptionCare at 1.866.515.1355 to set up auto-pay by phone.

3) **Paying by Check or Money Order via Mail.** Please make your check or money order payable to OptionCare Specialty Pharmacy, and return in the enclosed pre-paid envelope to: OptionCare Specialty Pharmacy, 1350 Highland Dr., Suite D, Ann Arbor, Michigan 48108.

## Allergy and Medication Questionnaire

- 1) Print and complete the Allergy and Medication Questionnaire. Please print clearly.
- 2) Mail Allergy and Medication Questionnaire, *and* Enrollment Form to: OptionCare Specialty Pharmacy, 1350 Highland Drive, Suite D, Ann Arbor, Michigan 48108.

If you have questions or concerns, please call the OptionCare Customer Care Team toll free at 1.888.282.5166. Our hours are Monday through Saturday, 8:00 a.m. to 8:00 p.m.; Sunday, 8:00 a.m. to 1:00 p.m. Eastern Standard Time.

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### Step 1: Demographic Information

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Day Phone Number w/area code \_\_\_\_\_ Evening Phone Number w/area code \_\_\_\_\_  
E-mail Address \_\_\_\_\_

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### Step 2: Patient Drug Allergy Information

Penicillin/Cephalosporin ( <i>ampicillin/Keflex</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tetracycline Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Codeine ( <i>e.g., Tylenol #3</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	Iodine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Non-steroidal anti-inflammatory drugs ( <i>e.g., ibuprofen</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other: ( <i>Please List</i> )			
_____			
_____			

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### Step 3: Patient Medication Profile

#### Prescription Medications

Name	Strength	Route	Directions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

#### Over-the-Counter Medications and Home Remedies

Name	Strength	Route	Directions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____