SPECIALTY MEDICATION PRESCRIPTION FORM

For questions about the program, please call the customer service number on the back of your member ID card or visit the prescription drug section of ccstpa.com.

PATIENT INFORMATION | **TODAY'S DATE:**

Patient Last Name:	Patient First Name:	MI	Sex: ☐ M ☐ F	DOB:
Patient Address:	City:		State:	Zip:
Home Phone:	Work Phone:		Best time to contact patient: ☐ AM ☐ PM	
Caregiver/Emergency Contact Name:	Relationship:		Phone:	
Special Instructions (allergies, pregnant, etc.):				

INSURANCE INFORMATION

Policyholder Name:	ID #:	
Employer:	Group Number:	Insurance Phone:

PHYSICIAN INFORMATION

Physician Last Name:	Physician First Name:	UPIN:	DEA:
Clinic Name:	Office Contact:	Phone:	Fax:
Clinic Address:	City:	State:	Zip:

PRESCRIPTION INFORMATION

Date Needed:	Quantity:	Refills:	Days Supply:
Drug Name:	Dose/Directions:		
Generic Substitutions Allowed: ☐ Yes ☐ No	Diagnosis:		
Physician Signature:			

DELIVERY INSTRUCTIONS

Location:	☐ Home	☐ Physician's Office	☐ Workplace	☐ Other
Address (if different form above):				
City:	State:	Zip:	PHONE:	