Fareston® 60mg
(toremifene citrate) Tablets

Prior Authorization Form

Customer Service/Live Support: **(844) 214-3442**
Fax completed form to: **(844) 214-3444**

patient Rx solutions

*Indicates required field

PRESCRIBER INFORMATION

*Prescriber Name (First, Last, Middle Initial):

*NPI #: License #:

Phone #:

Fax #: Contact Email:

*Address Street/Suite:

*State: *Zip:

PATIENT INFORMATION

*Patient Name (First, Last, Middle Initial):

*Date of Birth: *Gender: M ☐ F ☐

*Address:

*State: *Zip:

*Phone #: Cell #:

Email:

*Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Fill at Preferred Pharmacy

If patient prefers a specific pharmacy, complete the fields: *Pharmacy Name:

Address: City: Zip:

Phone #: Fax:

PRESCRIPTION INFORMATION

*Patient Name (First, Last):

Drug: **FARESTON® (toremifene citrate) 60 mg Tablets** Date:

Dose: 60 MG TABLET

*Quantity # of Tablets: Refill:

*Sig (Directions):

PATIENT INSURANCE INFORMATION

*Prescription Drug Insurer:

Policyholder Name: Relationship to Patient:

*Member ID #: *Group ID #:

*Rx BIN #: *PCN #:

Phone:

PRESCRIBER OFFICE CONTACT INFORMATION

*Office Contact Name (First, Last):

*Email: Phone #:

PATIENT DIAGNOSIS

*ICD-9 Code/ Description:

Allergies:

Type of Cancer:

Rx's Failed, Dosage, Dates of Therapy and Reason for Failure:

PROVIDER ATTESTATION

By my signature below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that Armada Specialty Pharmacy Network (ASPN) reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize ASPN as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow ASPN to email me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

☐ **Please send me status updates via email.** You may opt-in to receive e-mails from ASPN regarding the status of your patient's prescription. By agreeing to receive e-mails from ASPN, you acknowledge that ASPN will send standard e-mails to you via the Internet. Therefore, there is potential for these unencrypted emails to be intercepted by unauthorized third parties. If you share your e-mail account or computer with others, those parties may be able to access your confidential information. You should notify ASPN immediately if you wish to cease receiving e-mails or if your e-mail address changes. You should not use e-mails for emergencies.

*Prescriber's Signature

*Date of Signature

Signature is required to process the prescription. Stamped signatures are not permissible.

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