



Phone: (877) 644-4623
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Adherence Packaging Request

I. MEMBER INFORMATION	II. PHARMACY INFORMATION
Patient Name:	Pharmacy Name:
ID Number:	NPI:
Date of Birth:	Address:
Address:	City, State, Zip:
City, State, Zip:	Phone:
Primary Phone:	Fax:
	Pharmacy Contact:

III. Adherence Packaging Checklist

Please complete the following reasons for adherence packaging.

- Member has one of the following diagnosis:
 - HIV
 - Seizures
 - Visual Impairment
 - Severe and Persistent Mental Illness:
 - Schizophrenia
 - Bipolar Disorder
 - Major Depressive Disorder (MDD): ICD-10 F32 or F33
 - Cognitive Disorder:
 - Alzheimer's
 - Dementia
 - Traumatic Brain Injury (TBI)
 - Intellectual or Developmental Disorder (IDD)
- Member is receiving anti-rejection therapy for organ transplant
- Member resides in a residential program (Group Home, Assisted Living Facility, Nursing Home, ICF/MR, PRTF)
- Member is enrolled in the Lock-In Program
- Member is enrolled in Pain Management Program/Pain Contract where adherence packaging is required
- Adherence packaging is preventing a need for Home Health Services
- Prescriber requires member to receive adherence packaging (Prescriber Name: _____ Phone: _____)
- Pharmacist-determined Medical Necessity for adherence packaging (*please state reason below*):

Reason: _____

By signing below, I hereby acknowledge that all information is true and correct.

Pharmacist's Name: _____ Pharmacist's Signature: _____ Date ____/____/____

Your attestation may be audited to request proof of the exception reason. Dispensing fees paid in excess of 90-day supplies may be recouped if appropriate proof of member meeting criteria is not provided upon request.

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