SPECIALTY CARE PHARMACY

REQUEST FOR FINANCIAL ASSISTANCE

130 Pine State St., Suite C
Lillington, NC 27546

Fax Request To: 844-814-1944 Phone: 844-814-1943
Email Request To: specialtycare@realodiscountdrug.com

For additional forms, visit www.realospecialtycare.com

Please print clearly.

PATIENT INFORMATION

Patient Name: ______________ ❑Male ❑Female DOB: ______________

Address: ______________ City, State, Zip: ______________

Primary Phone: ______________ ❑Home ❑Cell ❑Work Alternate Phone: ______________ ❑Home ❑Cell ❑Work

Email: ______________ SSN: ______________

What is the patient's medical condition/diagnosis relative to this application? ______________

What drug/treatment is the patient being prescribed? ______________

PRESCRIBER INFORMATION

Prescriber Name: ______________ Office Contact: ______________

Address: ______________ City, State, Zip: ______________

Phone: ______________ Fax: ______________

NPI: ______________ DEA: ______________

CRITERIA FOR ADDITIONAL FUNDING

Number of people in patient's household (including patient): ______________

Is patient a legal U.S. resident? ❑yes ❑no

Patient's approximate annual gross household income: ______________

Does patient have insurance coverage? ❑yes ❑no

Does patient file federal and state income taxes annually? ❑yes ❑no

Does patient receive any wages, salaries, or additional income? ❑yes ❑no If yes, please specify amount: ______________

Does patient have investments (i.e. stocks, bonds) and/or retirement plans (401k, etc.)? ❑yes ❑no

Is patient receiving social security or disability? ❑yes ❑no If yes, please specify amount: ______________

INSURANCE INFORMATION

Primary Insurance: ______________ Prescription Insurance: ______________

Primary Health Insurance ID#: ______________ Prescription Insurance ID#: ______________

Primary Health Insurance Group #: ______________ Prescription Insurance Group #: ______________

Primary Health Insurance Phone #: ______________ Prescription Insurance Phone #: ______________

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.

REQUESTER INFORMATION

(If you are requesting on someone's behalf, please complete the section below.)

Requester's Name: ______________ Relationship to Patient: ______________

Address: ______________

Primary Phone Number: ______________ ❑cell Alternate Phone Number: ______________ ❑cell

Email Address: ______________

AUTHORIZATION

I authorize Realo to apply for and manage prescription assistance funding on my behalf.

Requester Signature: ______________ Date: ______________

Print Patient Name: ______________

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