Healthvia PHARMACY SPECIALTY CARE

Specialty Care **Close to Home™**

To Whom It May Concern,

I hereby authorize Healthvia Pharmacy or KloudScript, Inc. to act as my designee for initiating and coordinating insurance prior authorizations, nursing services, and patient assistance program coordination for prescription orders it receives for my patients. I understand that Healthvia Pharmacy will contract with a third-party, KloudScript, Inc. to assist with these services. I further authorize Healthvia Pharmacy or KloudScript, Inc. to use my caller ID information so that my number and name (or the name of my practice) is displayed when calling patients, insurance companies and other third-party payors or patient assistance providers. I will provide Healthvia Pharmacy or KloudScript, Inc. with all clinical information that is necessary in order to obtain prior authorization and patient assistance services necessary for my patients. I understand that prior authorization approval and insurance benefits will be determined by the payor based upon each patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things, and that participation in this program is not a guarantee of prior authorization or of payment. Upon request, Healthvia Pharmacy or KloudScript, Inc. will provide me with a copy of the information that was submitted for prior authorization. This authorization form will be active for one (1) year or until I retire or leave the practice, whichever is sooner. In the event any prior authorization obtained under this agreement expires, I understand that Healthvia Pharmacy or KloudScript, Inc. will contact my office to ensure that the affected patient is to continue treatment of the prescribed medication(s), and, if so, I understand that Healthvia Pharmacy or KloudScript, Inc. will send me a new prior authorization form for my signature. I hereby authorize Healthvia Pharmacy or KloudScript, Inc. to coordinate any such prior authorization or patient assistance programs as set forth above.

Signature: ……

Date: ……

Prescriber's Name: ……

Contact Phone: ……

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