# THN Pharmacy Referral

**Please fax referral to: 1-336-663-5372**

**300 East Wendover Ave. 4th floor**
**Greensboro, NC 27401**
**Central Pharmacy Team Phone: 1 (336) 663-5350**
**Monday-Friday**
**9 am-5 pm**

| **Referral Information** | | |
|---|---|---|
| Referral Date: | Time: | PCP:<br>THN PCP: Yes/No |
| Name of Contact Requesting Referral: | Phone: | Fax |

**Reason for Referral:**

- ☐ Medication Assistance
  Name of Medication(s) and Dose: _____
- ☐ Comprehensive Medication Review due to Clinical Indication(s)
  Clinical Indication(s):_____
- ☐ Medication Adherence Concerns
  Name of Medication(s): _____
- ☐ Medication Related Quality Gap
  Name of Medication(s): _____
- ☐ Medication Review or Medication Assistance for Emmi Stroke Transitions (*Any Payor, uninsured, Non THN*)
- ☐ Other; Please specify: _____

| **Patient Information:** | | |
|---|---|---|
| Patient name: | Patient DOB: | Patient Phone Number: |
| Has patient consented to pharmacy outreach? | Verbal Consent Obtained by: | Is Patient primary Contact? |
| | Date | If no, primary contact name and number: |

**Eligible Payors: *Traditional Medicare, Aetna Medicare Advantage (MA), Aetna Commercial, Blue Cross Blue Shield MA, Blue Cross Blue Shield Commercial, Cigna MA, Devoted Health MA, Friday Health Commercial, HealthTeam Advantage (HTA), Humana MA, UHC/AARP MA***

Insurance: Primary Payor: _____ Secondary Payor: _____

**Please signify desired time frame and reason for time frame for Outreach Assessment:**

**Urgent (within 24 business hours):** _____

**Routine (within 3 business days):** _____