Allergy Test & Treatment Program

Instructions for Enrollment

No Medicaid

There are 3 documents contained in this Enrollment Packet which need to be completed to enroll with the Allergy Test & Treatment Program. Please submit completed documents in a PDF to Enrollment@PediatricAllergySolutions.com

Lab Account Set-Up Form – *Setup Account to order tests* from lab
Please complete each field on all pages. Please provide best phone number (back-office, cell) to reach the Office Manager or contact person for practice.
Page 1 – Provide Signature
Page 3 – Each Provider must provide Signature

Allovate Account Set-up Form – *Setup Account to coordinate with pharmacy & practice*
Complete the Practice Information Section
Please list all Prescribers (attach a separate list if necessary)

Compounding Pharmacy Account Set-up Form – *Setup Account to send Prescriptions*
Complete the Practice Information Section
Please list all Prescribers *(attach a separate list if necessary)*
Complete, Sign and Date the Banking Information Section
Provide a copy of the Medical License for each provider

Please refer to table below to determine which pharmacy is assigned to your **State** so you will know which Compounding Pharmacy Account Set-up Form to complete. **Only complete the compounding pharmacy Account Set-up Form which is assigned to your state.**

States	Stanley Pharmacy	RiverPoint Rx	Allerlogix	Innovation	Athena Pharmacy
Alabama				X	
Alaska		X			
Arizona		X			
Arkansas*	X				
California		X			
Colorado					X
Connecticut			X		
Delaware				X	
Florida		X			
Georgia					X
Hawaii					X
Idaho		X			
Illinois					X
Indiana				X	
Iowa		X			
Kansas				X	
Kentucky					X
Louisiana					X
Maine					X
Maryland				X	

States	Stanley Pharmacy	RiverPoint Rx	Allerlogix	Innovation	Athena Pharmacy
Montana		X			
Nebraska					X
Nevada					X
New Hampshire					X
New Jersey			X		
New Mexico		X			
New York			X		
North Carolina					X
North Dakota					X
Ohio		X			
Oklahoma					X
Oregon		X			
Pennsylvania			X		
Rhode Island				X	
South Carolina					X
South Dakota				X	
Tennessee					X
Texas					X
Utah					X
Vermont				X	

Massachusetts					X
Michigan				X	
Minnesota				X	
Mississippi				X	
Missouri					X

** Ship to Patient Home Only*

Virginia					X
Washington		X			
Washington DC					X
West Virginia				X	
Wisconsin				X	
Wyoming				X	

Onboarding Process

1. Practice completes enclosed forms *(listed above)*
2. Sales Rep schedules the Implementation Training Webinar (in 2 weeks). Go to "Login" and login ("PAS123!" for PAS site or "OAS123!" for OAS site) and click on "Schedule Implementation Training Webinar". Enter Practice information. In note, enter Name of Practice and PAS or OAS account.
3. Practice will receive a welcome email with tracking information of shipped supplies from the Enrollment Team, along with two attachments:
    a. Implementation Manual *(covering all aspects of the program)*
    b. Customized Prescription Sheet *(pre-filled per provider - to be printed at practice as needed)*
4. Practice will receive an initial supply of Test Kits, Signs for each Exam Room and Reception area, and a supply of Trifolds from the home office.
5. Practice will receive a supply of shipping labels and bags from Lab.
6. Practice will receive portal login information from the Lab.
7. Practice will receive a Ring Central invite for the Implementation Training Webinar.
8. Implementation Training Webinar with Staff & Providers *(Sales Rep, home office and Medical Director).*

Implementation Process

1. Testing Process
    a. Test Patient
    b. Send Test Kit & Requisition Form & Patient Insurance info to Lab
    c. Receive Report *(via portal –1-2 weeks)*
2. Prescription Process
    d. Send Customized Prescription Sheet to Compounding Pharmacy
        i. See Implementation Manual FAQs for instructions
        ii. Call 800 Hotline at Allovate for assistance from an Allergist *(# in Implementation Manual)*
        iii. Call 800 Hotline at Pharmacy for assistance from a Pharmacist *(# on Prescription Sheet)*
    e. Compounding Pharmacy ships Finished Product *(toothpaste)* to Practice *(default)* or to Patient home *(optional)* as prescribed
3. Dispensing Process
    f. Patient comes to Practice for a quarterly checkup
    g. Patient receives next 90-day supply of Toothpaste
4. Billing & Shipping Options
    h. Practice bills Patient <u>before</u> sending Prescription to Pharmacy
        i. Suggest that practice sets-up auto payment for patient CC/EFT *(quarterly)*
    i. Pharmacy charges Practice for Finished Product *(Pharmacy mixes Serum and OMIT Base offsite)*
        i. Pharmacy ships Finished Product to Practice, or
    j. Pharmacy charges Patient *(if so instructed by provider) Retail Price ($264)*
        i. Pharmacy ships Finished Product to either Practice or Patient *(as prescribed)*
5. Maintenance Process
    k. Quarterly Patient Checkup *(review progress and dispense next 90-day prescription to Patient)*
    l. Annual Re-Test – Measure Outcomes – modify prescription if needed – based on new test result *(regimen typically lasts 3-5 years)*

LAB ACCOUNT SET-UP FORM

Blood Allergy Molecular Proteomic Test

Account ID#: _____ *(Assigned by home office)*

Account Information

Practice Name		
Address Line 1		
Address Line 2 (Suite #, Floor #, etc)		
City	State	Zip
Phone Number	Fax Number	
Facility Type ☐ Pediatrician ☐ ENT ☐ Internal Med/General Practice ☐ Other _____	Does this account utilize multiple locations? ☐ Yes ☐ No	

*Please note that additional locations require all corresponding documentation for onboarding.

Provider Information

Provider #1 Name		Provider #1 NPI Number	
License Number	Provider #1 Email	Signature	
Provider #2 Name		Provider #2 NPI Number	
License Number	Provider #2 Email	Signature	
Provider #3 Name		Provider #3 NPI Number	
License Number	Provider #3 Email	Signature	

*Please note that every healthcare provider that writes a prescription needs to be listed. If additional healthcare providers will be ordering from this location, please complete the below Provider Information sheet (page 3).

Contact Information

Main Office Contact	Title
Phone Number	Email
Result Portal Contact(if different from main office contact)	Title
Phone	Email

By signing below, I authorize the hospital/lab to send patient lab result reports to the above listed contact(s)

Office Manager or Physician (print) _____ Signature _____ Date _____

LAB ACCOUNT SET-UP FORM
Blood Allergy Molecular Proteomic Test

Account ID#: _____ *(Assigned by home office)*

Shipping Information - Patient Mix - Sales Representative

Shipping Preferences	
Do you already have regularly occurring **UPS/Fed Ex** Pickups? ☐ Yes ☐ No	Do you need regularly occurring **UPS/Fed Ex** Pickups Scheduled? ☐ Yes ☐ No
Pickup Start Date	Pickup Time (2 hour window)
Pickup Days ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	
Pickup Notes (Example: "pick up at front desk," "ring bell," etc.)	

Shipping Contacts	
Practice Shipping Contact	Phone Number
Email	
Check one ☐ Office Manager ☐ Account Manager ☐ Collector ☐ Other _____	
Sales Representative Shipping Contact	Phone Number
Email	

*Primary shipping contact will be the main point of contact for any pickups or inquiries. All shipping contacts will receive auto confirmation emails when an order is placed and when an order ships.

Patient Mix

Commercial PPO %:

Commercial HMO %:

Tricare %:

Medicare %:

Medicaid (N/A) %:

Sales Representative Information	
Program PAS/OAS Blood Allergy Molecular Proteomic Test	Representative Name / VRx ID #
Phone Number	Email

LAB ACCOUNT SET-UP FORM
Blood Allergy Molecular Proteomic Test

Account ID#: _____ *(Assigned by home office)*

Additional Provider Information Sheet - Original Signature on file for Lab Compliance

Practice Name _____ Date _____

Provider #4 Name (print)	Signature	
Provider #4 License Number	Provider #4 Email	Provider #4 NPI Number
Provider #5 Name (print)	Signature	
Provider #5 License Number)	Provider #5 Email	Provider #5 NPI Number
Provider #6 Name (print)	Signature	
Provider #6 License Number	Provider #6 Email	Provider #6 NPI Number
Provider #7 Name (print)	Signature	
Provider #7 License Number	Provider #7 Email	Provider #7 NPI Number
Provider #8 Name (print)	Signature	
Provider #8 License Number	Provider #8 Email	Provider #8 NPI Number

Allovate

Allergy Test & Treatment Program
Account Set-Up Form

PRACTICE INFORMATION:

Name of Practice: _____ VRX Sales ID#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____

Email: _____ Fax #: _____ # Mo. Patient Visits _____

Specialty: (Pediatrician, Allergist, etc.) _____ #of Exam Rooms: _____

Business Type: ☐ Sole Proprietor ☐ Corp ☐ Partnership ☐ LLC Fed Tax ID: _____

Collateral Material (Signs, Trifolds): ____ Pediatric ____ Optimum ____ I do NOT want to be listed on the website.

PRESCRIBER INFORMATION: *(attach separate sheet if necessary)*

Prescriber #1 Name: _____NPI#: _____

Email: _____ Phone: _____

Prescriber #2 Name: _____NPI#: _____

Email: _____ Phone: _____

Prescriber #3 Name: _____NPI#: _____

Email: _____ Phone: _____

Prescriber #4 Name: _____NPI#: _____

Email: _____ Phone: _____

Prescriber #5 Name: _____NPI#: _____

Email: _____ Phone: _____

Prescriber #6 Name: _____NPI#: _____

Email: _____ Phone: _____

Prescriber #7 Name: _____NPI#: _____

Email: _____ Phone: _____

Prescriber #8 Name: _____NPI#: _____

Email: _____ Phone: _____

PLEASE SEND COMPLETED FORM TO:

Enrollment@PediatricAllergySolutions.com

Admin Only: Account ID# _____

Allergy Test & Treatment Program
Compounding Pharmacy Account Set-Up Form

PRACTICE INFORMATION:

Name of Practice: _____ VRX Sales ID#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____

Email: _____ Fax #: _____

Specialty: (Pediatrician, Allergist, etc.) _____

Business Type: ☐ Sole Proprietor ☐ Corp ☐ Partnership ☐ LLC Fed Tax ID: _____

PRESCRIBER INFORMATION: *(attach separate sheet if necessary)*

Prescriber #1 Name: _____NPI#: _____

Email: _____ MED #: _____

Prescriber #2 Name: _____NPI#: _____

Email: _____ MED#: _____

Prescriber #3 Name: _____NPI#: _____

Email: _____ MED#: _____

BANKING INFORMATION:

ACH INFORMATION (Primary):

NAME ON ACCOUNT: _____

ROUTING #:_____ ACCOUNT #: _____

CREDIT CARD INFORMATION (Secondary):

TYPE OF CARD (Check one): ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DEBIT CARD ☐ PRO CARD

NAME ON CARD: _____

CARD #: _____EXPIRATION: _____/_____ SECURITY CODE: _____

BILLING ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

I hereby authorize Stanley Pharmacy to ACH our bank account or charge this debit/credit/pro card for any prescriptions filled which were written by one of our prescribers and for which have not been paid within 30 days of the billing date.

AUTHORIZED SIGNATURE: X_____ DATE:_____

PLEASE SEND COMPLETED FORM TO:

Enrollment@PediatricAllergySolutions.com

Admin Only: Account ID# _____

Allergy Test & Treatment Program
Compounding Pharmacy Account Set-Up Form

PRACTICE INFORMATION:

Name of Practice: _____ VRX Sales ID#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____

Email: _____ Fax #: _____

Specialty: (Pediatrician, Allergist, etc.) _____

Business Type: ☐ Sole Proprietor ☐ Corp ☐ Partnership ☐ LLC Fed Tax ID: _____

PRESCRIBER INFORMATION: *(attach separate sheet if necessary)*

Prescriber #1 Name: _____NPI#: _____

Email: _____ MED#: _____

Prescriber #2 Name: _____NPI#: _____

Email: _____ MED#: _____

Prescriber #3 Name: _____NPI#: _____

Email: _____ MED#: _____

BANKING INFORMATION:

ACH INFORMATION (Primary):

NAME ON ACCOUNT: _____

ROUTING #:_____ ACCOUNT #: _____

CREDIT CARD INFORMATION (Secondary):

TYPE OF CARD (Check one): ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DEBIT CARD ☐ PRO CARD

NAME ON CARD: _____

CARD #: _____EXPIRATION: _____/_____ SECURITY CODE: _____

BILLING ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

I hereby authorize Riverpoint Pharmacy to ACH our bank account or charge this debit/credit/pro card for any prescriptions filled which were written by one of our prescribers and for which have not been paid within 30 days of the billing date.

AUTHORIZED SIGNATURE: X_____ DATE:_____

PLEASE SEND COMPLETED FORM TO:

Enrollment@PediatricAllergySolutions.com

Admin Only: Account ID# _____

Allerlogix

Allergy Test & Treatment Program
Compounding Pharmacy Account Set-Up Form

PRACTICE INFORMATION:

Name of Practice: _____ VRX Sales ID#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____

Email: _____ Fax #: _____

Specialty: (Pediatrician, Allergist, etc.) _____

Business Type: ☐ Sole Proprietor ☐ Corp ☐ Partnership ☐ LLC Fed Tax ID: _____

PRESCRIBER INFORMATION: *(attach separate sheet if necessary)*

Prescriber #1 Name: _____NPI#: _____

Email: _____ MED#: _____

Prescriber #2 Name: _____NPI#: _____

Email: _____ MED#: _____

Prescriber #3 Name: _____NPI#: _____

Email: _____ MED#: _____

BANKING INFORMATION:

ACH INFORMATION (Primary):

NAME ON ACCOUNT: _____

ROUTING #:_____ ACCOUNT #: _____

CREDIT CARD INFORMATION (Secondary):

TYPE OF CARD (Check one): ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DEBIT CARD ☐ PRO CARD

NAME ON CARD: _____

CARD #: _____EXPIRATION: _____/_____ SECURITY CODE: _____

BILLING ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

I hereby authorize Allerlogix Pharmacy to ACH our bank account or charge this debit/credit/pro card for any prescriptions filled which were written by one of our prescribers and for which have not been paid within 30 days of the billing date.

AUTHORIZED SIGNATURE: X_____ DATE:_____

PLEASE SEND COMPLETED FORM TO:

Enrollment@PediatricAllergySolutions.com

Admin Only: Account ID# _____

INNOVATION COMPOUNDING

Allergy Test & Treatment Program
Compounding Pharmacy Account Set-Up Form

PRACTICE INFORMATION:

Name of Practice: _____ VRX Sales ID#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____

Email: _____ Fax #: _____

Specialty: (Pediatrician, Allergist, etc.) _____

Business Type: ☐ Sole Proprietor ☐ Corp ☐ Partnership ☐ LLC Fed Tax ID: _____

PRESCRIBER INFORMATION: *(attach separate sheet if necessary)*

Prescriber #1 Name: _____NPI#: _____

Email: _____ MED#: _____

Prescriber #2 Name: _____NPI#: _____

Email: _____ MED#: _____

Prescriber #3 Name: _____NPI#: _____

Email: _____ MED#: _____

BANKING INFORMATION:

ACH INFORMATION (Primary):

NAME ON ACCOUNT: _____

ROUTING #:_____ ACCOUNT #: _____

CREDIT CARD INFORMATION (Secondary):

TYPE OF CARD (Check one): ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DEBIT CARD ☐ PRO CARD

NAME ON CARD: _____

CARD #: _____EXPIRATION: _____/_____ SECURITY CODE: _____

BILLING ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

I hereby authorize Innovation Compounding to ACH our bank account or charge this debit/credit/pro card for any prescriptions filled which were written by one of our prescribers and for which have not been paid within 30 days of the billing date.

AUTHORIZED SIGNATURE: X_____ DATE:_____

PLEASE SEND COMPLETED FORM TO:

Enrollment@PediatricAllergySolutions.com

Admin Only: Account ID# _____

Allergy Test & Treatment Program
Compounding Pharmacy Account Set-Up Form

PRACTICE INFORMATION:

Name of Practice: _____ VRX Sales ID#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____

Email: _____ Fax #: _____

Specialty: (Pediatrician, Allergist, etc.) _____

Business Type: ☐ Sole Proprietor ☐ Corp ☐ Partnership ☐ LLC Fed Tax ID: _____

PRESCRIBER INFORMATION: *(attach separate sheet if necessary)*

Prescriber #1 Name: _____NPI#: _____

Email: _____ MED#: _____

Prescriber #2 Name: _____NPI#: _____

Email: _____ MED#: _____

Prescriber #3 Name: _____NPI#: _____

Email: _____ MED#: _____

BANKING INFORMATION:

ACH INFORMATION (Primary):

NAME ON ACCOUNT: _____

ROUTING #:_____ ACCOUNT #: _____

CREDIT CARD INFORMATION (Secondary):

TYPE OF CARD (Check one): ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DEBIT CARD ☐ PRO CARD

NAME ON CARD: _____

CARD #: _____EXPIRATION: _____/_____ SECURITY CODE: _____

BILLING ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

I hereby authorize Athena Pharmacy to ACH our bank account or charge this debit/credit/pro card for any prescriptions filled which were written by one of our prescribers and for which have not been paid within 30 days of the billing date.

AUTHORIZED SIGNATURE: X_____ DATE:_____

PLEASE SEND COMPLETED FORM TO:

Enrollment@PediatricAllergySolutions.com

Admin Only: Account ID# _____