Note: This form is intended for prescriber use only. If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

SPECIALTY PHARMACY Rx Phone: Provider Representative Phone Date Needed Ship to Prescriber's Office Other PATIENT INFORMATION DOP:	
	ork
Patient Name: DOB: Male Female	
Address:	
Phone # (Daytime): Phone # (Evening):	
E-mail Address:	
Insurance Provider (Please include copy of front and back of card):	
ID #: Policy/Group #: Phone #:	
Name of Insured: Employer:	
Relationship to Patient: Self Other: Patient is Eligible for Medica	TO
	ure
CLINICAL ASSESSMENT	
Patient is New to Therapy Primary Code Condition: Allergies: Patient is Restarting Therapy Patient is Currently on Therapy	
(Start Date:) Current Weight:(kg / lbs) Current Height:(kg / lbs)	(cm / in)
PRESCRIPTION INFORMATION	
MedicationFormStrengthQuantityDirections/FrequencyDose	Refills
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Prescriber's Name: Practice/Facility Name: Address: Contact:	
Prescriber's Name: Practice/Facility Name: Address: Contact:	-
Prescriber's Name: Practice/Facility Name: Address: Contact:	-
Prescriber's Name: Practice/Facility Name: Address: Contact: City: State: Zip Code: Phone #: Fax: Best Time to Call: State License #: DEA #: NPI#: Medicaid UPIN #:	
Prescriber's Name: Practice/Facility Name: Address: Contact:	
Prescriber's Name: Practice/Facility Name: Address: Contact: City: State: Zip Code: Phone #: Fax: Best Time to Call: State License #: DEA #: NPI#: Medicaid UPIN #: In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically	
Prescriber's Name: Practice/Facility Name: Address: Contact: Address: City: City: State: Zip Code: Phone #: Fax: Best Time to Call: State License #: DEA #: NPI#: Medicaid UPIN #: In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state specific required language to prohibit substitution:	

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

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