

\*\*\*Select one of our Central Pharmacy numbers from the drop-downs below, or type a Retail/Community Pharmacy number in the blank space provided

**Rx FAX:** \_\_\_\_\_

**Rx Phone:** \_\_\_\_\_

Provider Representative | Phone \_\_\_\_\_ Date Needed \_\_\_\_\_ Ship to  Specialty Care Center  Patient's Home  
 Prescriber's Office  Other \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
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 Medicare  
Prescription Card:  Yes  No Carrier: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

**CLINICAL ASSESSMENT**

Patient is New to Therapy  
 Patient is Restarting Therapy  
 Patient is Currently on Therapy (Start Date: \_\_\_\_\_)  
Primary ICD-9 Code and Condition: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Current Weight: \_\_\_\_\_ (kg / lbs) Current Height: \_\_\_\_\_ (cm / in)

**PRESCRIPTION INFORMATION**

Medication	Form	Strength	Quantity	Directions/Frequency	Dose	Refills

**PRESCRIBER INFORMATION**

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 Necessary,"** or your state specific required language to prohibit substitution: \_\_\_\_\_  
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.  
Prescriber's Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_  
Secondary Signature Optional: \_\_\_\_\_ Date: \_\_\_\_\_

**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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Drug names are the property of their respective owners.