REFERRAL FORM

SIGN AND FAX THIS FORM TO 877.828.3939
If you have questions, please call 877.627.MEDS (6337)

PATIENT/PRESCRIBER

PATIENT INFORMATION		PRESCRIBER INFORMATION	
First name: MI:		Title: First name:	
Last name:		Last name:	State license #:
Patient DOB: Sex:		Provider NPI #:	DEA #:
Address:		Office name:	Office contact:
City/State/Zip:		Address:	
Primary phone:		City/State/Zip:	
Alternate phone:		Phone:	Fax:

INSURE

FAX A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARD(s)

Primary insurance:	Policy ID #:	Group #:	
Policyholder name:	Policyholder DOB:	PCN:	BIN:

CLINICAL

Primary diagnosis:	Height:	Weight:
ICD 9:	Allergies:	
Other health conditions:	Current medications:	

PRESCRIPTION INFORMATION

Date needed: ☐ New prescription ☐ Refill prescription ☐ New to therapy ☐ Restarting therapy

Delivered to: ☐ Patient's home ☐ Prescriber's facility ☐ Other: _____

Medication Form / Strength / Dose / Directions / Frequency / Quantity

☐ Check here if you would like the associated supplies dispensed along with injectable medications. State restrictions apply. Separate prescriptions are required in some jurisdictions.

REFILLS: NR 1 2 3 4 5 _____

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS.

☐ **Dispense as written/Do not substitute** **Date**

☐ **Substitution permitted/Brand exchange permitted** **Date**

For states requiring hand-written expressions of product selection use this area (e.g. medically necessary, may not substitute, dispense as written, etc.).