

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:	<input type="checkbox"/> New prescription	<input type="checkbox"/> Refill prescription	<input type="checkbox"/> New to therapy	<input type="checkbox"/> Restarting therapy
	Delivered to:	<input type="checkbox"/> Patient's home	<input type="checkbox"/> Prescriber's facility	<input type="checkbox"/> Other: _____	
	Medication Form / Strength / Dose / Directions / Frequency / Quantity				
<input type="checkbox"/> 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.).

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