

First ship to: Patient Physician Need by date:

Patient			
Patient name:			
Date of birth:	Height:	Weight:	lb kg
Address:		City:	State: ZIP:
Home number:	Work number:	Cell number:	Best time to call: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Social Security number:		Language:	
Primary language:		Allergies:	<input type="checkbox"/> No known drug allergies (NKDA)

Provider			
Physician name:		Practice name:	
National Provider Identifier (NPI) number:		State license number:	
Address:		City:	State: ZIP:
Drug Enforcement Administration (DEA) number (Optional for non-controls):		Phone:	Fax:
Key office contact name:		Phone:	

Insurance*		
Primary insurance:	ID number:	Phone:
Secondary insurance:	ID number:	Phone:
BIN:	PCN:	Group No.:

*Please provide a copy of the insurance card (front and back).

Clinical information	
Diagnosis: _____ <input type="checkbox"/> ICD9: _____ <input type="checkbox"/> ICD10: _____	Diagnosis Date:
Current medications:	
Other pertinent past medical history and drug therapy:	
Previously treated: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list therapy:	Dates:

*Please attach copies of pertinent labs and clinical information in order to assist us in obtaining prior authorization approval.

Prescription information				
Medication	Dose/Strength	SIG	Quantity	Refills

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS. (STAMPS NOT ACCEPTED)			
Prescriber signature:		Prescriber signature:	
<input type="checkbox"/> Dispense as written/Do not substitute	Date:	<input type="checkbox"/> Substitution permitted/Branded exchange permitted	Date:

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

