


<input type="checkbox"/> New to Therapy
<input type="checkbox"/> Current Therapy

Patient Information	
Patient Name: _____	
Date of Birth: _____ Gender: <input type="checkbox"/> Male or <input type="checkbox"/> Female	
Address: _____	
City: _____	State: _____ Zip: _____
Home Phone: _____	Work Phone: _____
Cell Phone: _____	E-mail: _____
Please attach copy of front and back of patient's prescription ins. card(s) if applicable	
Insurance Company Name: _____	
Insurance Company Phone: _____	
Policy holder: _____	
Policy holder Employer: _____	
Relationship to Patient: _____	
ID# _____	Group# _____
RxBIN: _____	RxPCN: _____

Prescriber Information	
Practice/Organization Name: _____	
Physician Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Phone#: _____	Fax#: _____
DEA# _____	NPI# _____
License#: _____	Medicaid UPIN#: _____
Physician Specialty: _____	

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Clinical Information and Prescription	
Primary Diagnosis: ICD-10 Code: _____	
Description: _____	
Date of Diagnosis or Years with Disease: _____	
Patients Allergies: _____	
Latex allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Weight: _____	Patient Height: _____ Date: ____/____/____
	
Refills Authorized: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other: _____	
Date Shipment Needed: _____ Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Prescriber <input type="checkbox"/> Clinic	
Shipment Address: _____ Attn: _____	
City: _____ State: _____ Zip: _____	
<i>If shipped to the physician's office, physician accepts on behalf of patient for administration in office.</i>	
X _____	Date: ____/____/____
Physician Signature (no stamps)	
If physician requests Brand Name only, DAW MUST be HANDWRITTEN in the following space provided:	
