Physician Order

General Medical Prescriptions

TEL: 702.701.7741 | Secure Referral Fax: 312-277-9575

PATIENT INFORMATION:			PRESCRIBER INFORMATION:		
Patient Name:			Prescriber Name:		
Address 1:			DEA:		
Address 2:			NPI:	UPIN:	
City:	State:	Zip:	Address:		
Home Phone:	Alt:		City	State:	Zip:
DOB:	SSN:	Gender: ☐ M ☐ F	Phone:	Fax:	
Language: ☐ English ☐ Spanish ☐ Other:			POC:	Email:	

INSURANCE INFORMATION: (Complete entirely or fax front and back of patient's prescription card)

Prescription Card:	Name of Insurer:	ID#:	BIN:	PCN:	Group:
Primary Insurance:	Subscriber:	ID#:	Name of Insurer:	Phone:	
Secondary Insurance:	Subscriber:	ID#:	Name of Insurer:	Phone:	

CLINICAL INFORMATION: (Attach additional sheets if necessary)

ICD DIAGNOSIS CODE:

☐

☐ Other:

Prior Therapy: ☐ NO ☐ YES | If Yes, Approx. End Date:

Reason for Discontinuance:

PATIENT HISTORY:

Weight: ☐ kg ☐ lb Height: ☐ cm ☐ in

☐ NKDA ☐ Allergies:

Comorbidities:

Concurrent Meds:

PRESCRIPTION INFORMATION: ☐ Ship To Patient ☐ Ship To Physician's Office ☐ Injection Training Required? ☐ YES ☐ NO

Medication	Dose	Route	Directions	Qty	Refills

Prescriber Authorization : I authorize this pharmacy and its representatives to act as my agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.

Prescriber Signature: _____ Date: _____