

1 PATIENT INFORMATION:

Name: _____ Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt Phone: _____
 Email: _____
 DOB: _____ M F Last 4 of SSN: _____

2 PRESCRIBER INFORMATION:

Name: _____ Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Office Contact: _____ Phone: _____

3 INSURANCE INFORMATION: *Please attach front and back copies of prescription/medical insurance card(s).*

4 CLINICAL INFORMATION: *To expedite prior authorization, please attach relevant clinical documentation.*

Primary ICD-10: _____ Drug Allergies: NKDA _____

If prior authorization is denied, preferred alternatives or the option to appeal, if available, will be provided to the office.

Additional Information: _____

5 INJECTION TRAINING: Physician to Train Pharmacist to Train Other: _____

6 PRODUCT DELIVERY: Physician's Office Patient's Home Other: _____

PRESCRIPTION INFORMATION:

Medication	Dose/Strength	Directions	Qty	Refills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

I authorize Pharmaca and its affiliates to act on my behalf to obtain prior authorization and/or other assistance if applicable. I acknowledge that prior authorization/payment is not guaranteed.

PHYSICIAN SIGNATURE REQUIRED

X _____ X _____
 Substitution Permitted Date Dispense as Written Date