

Specialty Order Form

Patient Information			Clinical Information		
Last name	First name	MI	Primary ICD-10 code		
Date of birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F		Other Diagnosis code		
Street Address		Apt. #	<input type="checkbox"/> NKDA <input type="checkbox"/> Known drug or food allergies _____		
City	State	ZIP	Height	Weight	
Home phone	Work phone		List supplies, any other prescription, over the counter, and herbal medications taken regularly:		
Cell phone					
Email address					
Parent/Guardian/Emergency contact					
Phone	Relationship				
Patient's primary language <input type="checkbox"/> English <input type="checkbox"/> Other, please specify _____					
Patient Insurance Information			Prescriber Information		
<i>Complete information below OR copy and attach both the front and back of the patient's prescription insurance card(s)</i>			Prescriber's name _____ Date _____		
Insurance company	Phone		Title (please check one) <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA		
Insured's name			If Nurse Practitioner or Physician Assistant, physician agreement under direction of Dr.		
Insured's employer			Office contact		
Relationship to patient			Street address	Suite #	
Identification #	BIN #		City	State	ZIP
Policy #	Group #	PCN #	Phone	Fax	
Is patient eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No			NPI #	License #	
I consent to auto-enrolling me in available patient assistance program(s) <input type="checkbox"/> Y <input type="checkbox"/> N			DEA #	XDEA #	
			Deliver product to:		
			Shipping address (if different than above) <input type="checkbox"/> Office <input type="checkbox"/> Patient's home <input type="checkbox"/> Clinic		

Medication	Strength/Form	Directions	Quantity/Refills
			Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy.		As needed for administration.	Sufficient quantity for medication dosage.

The prescriber is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

By signing below, I certify that the above therapy is medically necessary.

Prescriber's signature (Physician attests this is their legal signature. **NO STAMPS.**) _____

Date	Substitution allowed	Date	Dispense as written
------	----------------------	------	---------------------

CONFIDENTIALITY NOTICE: The information contained in this communication is confidential and intended for health care treatment. You are obligated to maintain it in a safe, secure and confidential manner. Redisclosure of this information is prohibited except as other permitted by applicable law or appropriate consent. If you are not the intended recipient of this message, or the employee or agent responsible for delivery to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is strictly prohibited. If you have received this message in error, please notify the sender.