Specialty Order Form

Patient Information

Last name	First name	MI
Date of birth	Gender ☐ M ☐ F	
Street Address		Apt. #
City	State	ZIP
Home phone	Work phone	
Cell phone		
Email address		
Parent/Guardian/Emergency contact		
Phone	Relationship	
Patient's primary language ☐ English ☐ Other, please specify _____		

Patient Insurance Information

Complete information below OR copy and attach both the front and back of the patient's prescription insurance card(s)

Insurance company	Phone	
Insured's name		
Insured's employer		
Relationship to patient		
Identification #	BIN #	
Policy #	Group #	PCN #
Is patient eligible for Medicare? ☐ Yes ☐ No		
I consent to auto-enrolling me in available patient assistance program(s) ☐ Y ☐ N		

Clinical Information

Primary ICD-10 code

Other Diagnosis code

☐ NKDA ☐ Known drug or food allergies _____

Height	Weight

List supplies, any other prescription, over the counter, and herbal medications taken regularly:

Prescriber Information

Prescriber's name	Date

Title (please check one) ☐ MD ☐ DO ☐ NP ☐ PA

If Nurse Practitioner or Physician Assistant, physician agreement under direction of Dr.

Office contact

Street address	Suite #	
City	State	ZIP
Phone	Fax	
NPI #	License #	
DEA #	XDEA #	

Deliver product to:

Shipping address (if different than above) ☐ Office ☐ Patient's home ☐ Clinic

Prescription Information

Medication	Strength/Form	Directions	Quantity/Refills
			Dispense: ☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ 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