

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

Patient Information

Patient Name: _____
 Date of Birth: _____ Gender: Male or 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: yes no
 Patient Weight: _____ Patient Height: _____ Date: _____



Date Shipment Needed: _____ **Ship to:** Patient Prescriber Clinic
Shipment Address: _____ **Attn:** _____
 City: _____ State: _____ Zip: _____

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

X

Physician Signature (no stamps) _____ **Date** _____
If physician requests Brand Name only, DAW
MUST be HANDWRITTEN in the following space provided: