

PATIENT INFORMATION

PRESCRIBER INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Primary Phone: _____ Alternate Phone: _____
 Email: _____ Gender: M F
 DOB: _____ Last Four of SSN: _____
 Preferred Language: _____

Prescriber's Name: _____
 DEA #: _____ NPI #: _____
 Group or Hospital: _____
 Address: _____
 City, State, Zip: _____
 Phone #: _____ Fax #: _____
 Contact Person: _____ Contact's Phone: _____

INSURANCE INFORMATION (Please FAX copy of prescription and insurance cards (front and back) with this form, if available)

Primary Insurance: Name of insurer _____ ID # _____ BIN _____ PCN _____ Group _____
 Secondary Insurance: Name of insurer _____ ID # _____ BIN _____ PCN _____ Group _____

DIAGNOSIS AND CLINICAL INFORMATION (Please FAX recent labs and clinical notes with prescription to expedite Prior Authorization)

<u>Diagnosis Description</u>	<u>ICD-10 Code</u>	
_____	_____	Needs By Date: _____
_____	_____	<input type="checkbox"/> New Therapy <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart
Date of Diagnosis: _____		Current Therapy: _____
Injection training provided by:		Will the patient be stopping the above medication before starting new therapy?
<input type="checkbox"/> Doctor office <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes Discontinuation Date: _____
		<input type="checkbox"/> No
		Has the patient failed other therapies in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No
		If so, please list: _____

Patient Clinical Information:

Allergies: _____	Weight: _____ lb/kg
Concomitant Medications: _____	Height: _____ in/cm

Additional Comments: _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills

X _____ (Date)
 PRODUCT SUBSTITUTION PERMITTED

X _____ (Date)
 DISPENSE AS WRITTEN

Only 1 medication is allowed per order form for VA/OH/MO/VT. Please use a new form for each medication.

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