

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"/> No known drug allergies _____ <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				Prescriber information			
Phone		Relationship		Prescriber's name		Date	
Patient's primary language <input type="checkbox"/> English <input type="checkbox"/> Other, please specify				Title <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA			
Patient insurance information				If nurse practitioner or physician assistant, physician agreement under direction of doctor			
<i>Complete information below OR copy and attach both the front and back of the patient's prescription insurance card(s)</i>							
Insurance company			Phone	Office contact			
Insured's name			Street address		Suite #		
Insured's employer			City		State	ZIP	
Relationship to patient			Phone		Fax		
Identification #		BIN #		NPI #		License #	
Policy #		Group #		PCN #	XDEA #		
Is patient eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				Deliver product to:			
I consent to Prime Therapeutics Specialty Pharmacy auto-enrolling me in available patient assistance program(s) <input type="checkbox"/> Yes <input type="checkbox"/> No				Shipping address (if different than above) <input type="checkbox"/> Office <input type="checkbox"/> Patient's home <input type="checkbox"/> Clinic			
Prescription information							
Medication	Strength/Form		Directions	Quantity/Refills			
				Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> Other _____ <input type="checkbox"/> 3-month supply <input type="checkbox"/> 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 ePrescribing, state-specific prescription form, fax, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.							
By signing, 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	

Please fax completed form to 866.364.2673. For questions about our pharmacy, contact us at 866.554.2673.

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*** This form is not valid in the state of Arizona. ***