PRESCRIPTION REFERRAL FORM

Phone: 866.413.3156 Fax: 877.834.1231 / faxes@repharmacy.com

Date Medication Needed: ______ Ship To: ( ) Patient's Home ( ) Prescriber's Office ( ) Pick-up (store location): ______ Injection training by pharmacy? ☐

1. Patient Information | Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: ______ Birthdate: ______
Soc. Sec. #: ______ Preferred Phone: ______
Address: ______
Alternate Caregiver Name: ______

Sex: ( ) Male ( ) Female Height: ______ Weight: ______ ( ) lbs. ( ) kg.
Known Allergies: ______
City: ______ State: ______ Zip: ______
Preferred Phone: ______

2. Prescriber Information

Provider Name: ______ Specialty: ______
Address: ______
City, State, Zip: ______

DEA#: ______ NPI#: ______ Tax ID#: ______
Phone: ______ Fax: ______
Key Contact: ______ Phone: ______

3. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Body Weight: ______ lb/Kg Age: ______ Adult/Pediatric: ______

Diagnosis:
- ☐ ICD-10
- ☐ ICD-10
- ☐ ICD-10
- ☐ ICD-10

Lab Work:
- ☐
- ☐
- ☐
- ☐ ______
- ☐
- ☐

History / Current Medical Status:
- ☐ Uncontrolled BP - BP record: ______
- ☐ Seizures disorder - Specify: ______
- ☐ Pregnant / Nursing: ______
- ☐ Heart disease - Specify: ______
- ☐ Stroke / DVT / PT: ______
- ☐ Bleeding Disorder - Specify: ______
- ☐ Any Allergy - Specify: ______
- ☐ Patient been previously on any ESA Therapy? ( ) Yes ( ) No
  Drug Name: ______ For how long?: ______

4. Prescription Information

Drug Name	Strenght	Dose / Frequency / Route	Refill

5. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature ______ **Date** ______

6. Prescriber Signature

Prescriber, please sign and date below

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written ______ **Date** ______ **Substitution Permissible** ______ **Date** ______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

# of Prescriptions: ______

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

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