

Patient Information						PATIENT DEMOGRAPHIC IS ATTACHED	
Last Name		First Name		Home Phone		Work/Mobile Phone	
Home Address				City		State	ZIP
Temporary Address or Shipping Address (if different from above)				City		State	ZIP
Social Security Number		Date of Birth	Gender (M/F)	Weight	Height	Diagnosis	
Special Instructions (allergies, language preference, etc.)							
Primary Caregiver/Phone				Emergency Contact/Phone			

Healthcare Provider Information: *Indicates Required Field							
Practice/Facility Name		Physician First and Last Name*		Phone*		Fax	
Address*				City*		State*	ZIP*
Physician NPI#*		Physician DEA#		Physician State License #			
Nurse/Key Contact			Phone or Pager Number		Email		

Insurance Information					
Primary Insurance		Phone	Name/SSN of Insured	ID Number	Group Number
Secondary Insurance		Phone	Name/SSN of Insured	ID Number	Group Number
Other Insurance/Prescription Drug Vendor (Rx Bin #)					

Additional Information			
Today's Date	Date Meds Needed	May we contact this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Information/Instructions

Medication	Dose/Strength	Sig	Quantity	Refills
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

INSURANCE CARD FRONT AND BACK	PATIENT DEMOGRAPHIC ATTACHED
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In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRESCRIBER MUST MANUALLY SIGN THIS FORM - (STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED)

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) _____ DISPENSE AS WRITTEN/Do Not Substitute (date) _____

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