

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ Sex: _____ SS# _____
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

Physician Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____ Fax#: _____
DEA# _____ NPI# _____
License#: _____ Medicaid UPIN#: _____
Physician Specialty: _____
☒ **Ship Product to: Physician or Clinic**
Office Contact: _____
Date Shipment Needed: _____
Shipment Address: _____
City: _____ State: _____ Zip: _____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

CLINICAL INFORMATION

Primary Diagnosis (ICD-9 Code): _____
Description: _____
Date of Diagnosis or Years with Disease: _____
Patient's Allergies: _____

Latex Allergy: ☐ YES ☐ NO

PRESCRIPTION INFORMATION



Quantity Prescribed: _____
Refills Authorized: ☐ NR ☐ 1RF ☐ 2RF ☐ 3RF ☐ 4RF ☐ 5RF
☐ 6RF ☐ 12RF ☐ Other: _____

X

Physician Signature (no stamps)

Date

If physician requests Brand Name only, DAW

MUST be HANDWRITTEN in the following space provided: