Phone: 844-309- 7171
Fax: 844-309-7173

## 1. Patient Information

Patient: _____ □ male □ female DOB: _____ SS#: _____
last name, first name

Address: _____
street city state zip

Primary Phone Number: _____ □ cell Alternate Phone Number: _____ □ cell

## 2. Insurance Information: please fax copy of prescription and insurance cards with this form (front + back).

| | | |
|---|---|---|
| Medical Insurance: | Policy Holder: | Phone #: |
| Group #: | Policy #: | BIN# PCN# |

## 3. Prescription

| Drug | Dosage | Directions | Quantity | Refills |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## 4. Prescriber Information

Prescriber's Name (print): _____ Office Contact: _____

Preferred Method of Contact: ☐ phone ☐ fax ☐ email Preferred Contact Persons Email: _____

Phone: _____ Fax: _____ NPI: _____ DEA: _____

Address: _____

City, State, Zip: _____

Prescriber's Signature: PHYSICIAN SIGNATURE REQUIRED –stamp signature not allowed Date: _____

I authorize STORE NAME, including its representatives and subcontractors to act as my agent to initiate and execute the insurance prior authorization process.

## 5. Diagnosis and Clinical Information

| -please include diagnosis name and code: | | Additional Clinical Information: |
|---|---|---|
| ICD9 or ICD10 | Description | Therapy: ☐ New ☐ Reauthorization ☐ Restart<br>Height: |
| | | Weight: |
| | | Allergies: |
| | | Concomitant Medications: |

Additional Comments:

Has patient received injection training? ☐ Yes ☐ No ☐ N/A

Please fax to AllyScripts Specialty Pharmacy at 844-309-7173.
Faxed prescription forms will only be accepted from prescribing practitioners.