866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please contact us!
www.REPharmacy.com

Prescription Referral Form

Send your Rx to: ____________________

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:

____

Tried and Failed Medication:

____

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.