PRESCRIPTION REFERRAL FORM

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

RE SPECIALTY PHARMACY

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: _____ Sex: (○) Male (○) Female Height: _____ Weight: _____ ( ) lbs. ( ) kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Caregiver Name: _____ Preferred Phone: _____

2. Prescriber Information

Provider Name: _____ Specialty: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ 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	Strength	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: To be administered by a healthcare professional. This document is intended solely for the designated recipient and contains confidential privileged, or legally protected information. If you are not the intended recipient, you are prohibited from disseminating, distributing, or copying this document. Please notify the sender immediately if you have received this document in error and promptly destroy it. By signing this form and using our services, you authorize RE Pharmacy and its employees to act as your designated agent for prior authorization in dealings with medical and pre scription insurance companies.

# of Prescriptions: _____