



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

# Pain Management Referral Form

Send your Rx to: \_\_\_\_\_

Date Medication Needed: \_\_\_\_\_ Ship To: ( ) Patient's Home ( ) Prescriber's Office ( ) Pick-up (store location): \_\_\_\_\_

**1. Patient Information**

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. Insurance Information** Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

**3. Prescriber Information**

Provider Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI#: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Key Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**4. Prescription Information**

_____ % Bupivacaine 1% Clonidine 0.2% Doxepin 5% Gabapentin 6% Sig. _____ Refill _____ NR Quantity _____	Amantadine 8% Bupivacaine 1% Diltiazem 2% Doxepin 3% Gabapentin 6% Orphenadrine 5% Topiramate 2% Sig. _____ Refill _____ NR Quantity _____	Ketoprofen 10% Ibuprofen 10% Cyclobenzaprine 2% Piroxicam 2% Lidocaine 2% Sig. _____ Refill _____ NR Quantity _____
_____ % Bupivacaine 1% Carbamazepine 3% Doxepin 6% Gabapentin 6% Topiramate 1% Sig. _____ Refill _____ NR Quantity _____	_____ % Bupivacaine 1% Doxepin 3% Gabapentin 6% Ketorolac 0.5% Ayclovir 5% Sig. _____ Refill _____ NR Quantity _____	_____ % Bupivacaine 1% Doxepin 3% Gabapentin 6% Nifedipine 2% Sig. _____ Refill _____ NR Quantity _____
_____ % Bupivacaine 1% Diclofenac 3% Doxepin 3% Gabapentin 6% Orphenadrine 5% Sig. _____ Refill _____ NR Quantity _____	_____ % Baclofen 2% Bupivacaine 1% Cyclobenzaprine 2% Gabapentin 6% Orphenadrine 5% Sig. _____ Refill _____ NR Quantity _____	_____ % Diclofenac 3% Baclofen 2% Bupivacaine 1% Ibuprofen 3% Sig. _____ Refill _____ NR Quantity _____  <b>Other</b> Sig. _____ Refill _____ NR Quantity _____

**5. 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: \_\_\_\_\_