



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

Specialty Pharmacy Referral Form

Send your RX to:

Date Medication Needed: _____ Injection training by pharmacy?

Ship to: Patient's Home Prescriber's Office Pick-up (store location): _____

1. PATIENT & INSURANCE INFORMATION
 (Please include copies of the FRONT and BACK of ALL insurance cards with this fax (Prescription and Medical))

Patient Name: _____ Birth Date: _____ Gender: Male Female
 Height: _____ Weight: _____ lbs. kg.
 SS#: _____ Preferred Phone: _____ Known Allergies: _____

 Address: _____ City: _____ State: _____ ZIP: _____
 Insurance Info: _____ Policy Number: _____

2. PRESCRIBER INFORMATION

Provider Name: _____ DEA#: _____ NPI#: _____ TAX ID#: _____
 Address: _____ Phone: _____ Fax: _____
 City, State, ZIP: _____ Key Contact: _____ Phone #: _____

3. PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS

4. 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. Please attach all patient-related document here.

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.

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

#of Prescriptions