For assistance, contact your pharmacy representative: _____ Phone:_____**(For providers only)**

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

Universal

Prescription/Pharmacy Intake Form

Pharmacy: _____
Pharmacy Fax: _____ Pharmacy Phone:_____
Date Needed: _____ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female
Address:_____
City: _____State:_____ Zip code:_____
Phone # (Daytime):_____ Phone # (Evening):_____
E-mail Address: _____ Case Manager: _____

Insurance provider **(Please include copy of front and back of card)**: _____
ID #: _____ Policy/Group #:_____ Phone #: _____ ☐Patient is eligible for Medicare
Name of Insured: _____ Employer:_____
Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #:_____
Will there be access to anaphylactic medications and oxygen at the administration site?_____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is restarting therapy ☐Patient is currently on therapy Start date: _____
Primary Diagnosis Code and Condition (ICD-10):_____Date of Diagnosis:_____
Other Diagnosis/Conditions:_____
Current Weight: _____ ☐lb ☐kg Date: _____ Current Height:_____ ☐in ☐cm Date: _____
☐Other Therapies Tried & Failed (Please List):_____
Allergies: _____

PRESCRIPTION INFORMATION

Medication	Form	Strength	Quantity	Directions/Frequency	Dose	Refills

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility:_____
Address:_____ City: _____ State: _____ Zip code: _____
Office contact: _____ Phone: _____ Fax:_____
Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax
State license #:_____ DEA #: _____ NPI #:_____ Medicaid UPIN #:_____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ _____ _____
Dispense as written Substitution permitted Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.
Drug names are the property of their respective owners.
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