

Specialty order form

Patient information							Clinical information						
Last name	First name			MI		Primary ICD-10 code							
Date of birth	Gender □ M □ F						Other diagnosis code						
Street address					Apt.#		□ No known drug allergies □ Known drug or food allergies						
City			State		ZIP		Height		Weight				
Home phone	Work		phone			List supplies, any other prescription, over-the-counter and herbal medications taken regularly:							
Cell phone													
Email address													
Parent/Guardian/Emergency contact							Prescriber information						
Phone	e Rela		ionship				Prescriber's n	name Date					
Patient's primary language	atient's primary language \Box English \Box O				ther, please specify			Title					
Patient insurance information						If nurse practitioner or physician assistant, physician agreement under direction of doctor							
Complete information below OR copy and attach both the front and back of the patient's prescription insurance card(s)													
Insurance company				Office contac	act								
Insured's name				Street addres	et address		Suite #						
Insured's employer							City		State ZIP			ZIP	
Relationship to patient							Phone	Fax					
Identification #			BIN#				NPI#		Lic	License #			
Policy #		Group #			PCN#		DEA#		XD	XDEA #			
Is patient eligible for Medicare? ☐ Yes ☐ No							Deliver product to:						
I consent to Prime Therapeutics Specialty Pharmacy auto-enrolling me in available patient assistance program(s) \square Yes \square No						Shipping address (if different than above) ☐ Office ☐ Patient's home ☐ Clinic							
Prescription information													
Medication	Strengt	:h/Forn	n	Directions			Quantity/Refills Dispense: □ 1-month supply □ Other □ 3-month supply □ Refills						
☐ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy.						eeded for administration Sufficient quantity for medication dosage							
The prescriber is to comply with their state-specific prescription requirements such as ePrescribing, state-specific prescription form, fax, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.													
By signing, I certify that the above therapy is medically necessary. Prescriber's signature (Physician attests this is their legal signature. No stamps.)													
Date	ate Substitution allowed						Date	Date Dispense as written					

Please fax completed form to 866.364.2673. For questions about our pharmacy, contact us at 866.554.2673.

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*** This form is not valid in the state of Arizona. ***