Prime THERAPEUTICS™

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	Relationship		Prescriber's name	Date
Patient's primary language ☐ English ☐ Other, please specify			Title ☐ MD ☐ DO ☐ NP ☐ PA	
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	Phone		Office contact	
Insured's name			Street address	Suite #
Insured's employer			City	State ZIP
Relationship to patient			Phone	Fax
Identification #	BIN #		NPI #	License #
Policy #	Group #	PCN #	DEA #	XDEA #
Is patient eligible for Medicare? ☐ Yes ☐ No			Deliver product to:	
I consent to Prime Therapeutics auto-enrolling me in available patient assistance program(s) ☐ Yes ☐ No			Shipping address (if different than above) ☐ Office ☐ Patient's home ☐ Clinic	

Prescription information

Medication	Strength/Form	Directions	Quantity/Refills
			Dispense: ☐ 1-month supply ☐ Other _____ ☐ Refills _____

☐ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy.

☐ As needed 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. Noncompliance with state-specific requirements could result in outreach to the prescriber.

Prescriber signature required in appropriate section below (stamp signature not allowed)
By signing, I certify that the above therapy is medically necessary. Prescriber signature (Physician attests this is their legal signature.)

Dispense as written / Brand medically necessary / Do not substitute / No substitution / DAW / May not substitute	May substitute / Product selection permitted / Substitution permissible
Prescriber's signature: _____ **Date:** _____	**Prescriber's signature:** _____ **Date:** _____

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

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