Prime THERAPEUTICS Pharmacy™

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 Specialty Pharmacy 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 _____ ☐ 3-month supply ☐ 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. 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	Substitution allowed	Date	Dispense as written

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

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

PrimeTherapeutics.com/SpecialtyPharmacy

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