PRESCRIPTION REFERRAL FORM

If you need a medication not listed, please call 855-79-0100 or email us at info@chemistryrx.com

Date Medication Needed: ______ **Ship To:** ○ Patient's Home ○ Prescriber's Office ○ Pick-up (store location): ______ Injection training by pharmacy? ☐

Patient Information

Patient Name: ______ **Birthdate:** ______ **Sex:** ○ Male ○ Female **Height:** ______ **Weight:** ______ ○ lbs. ○ kg.

Soc. Sec. #: ______ **Preferred Phone:** ______ **Known Allergies:** ______

Address: ______ **City:** ______ **State:** ______ **Zip:** ______

Alternate Caregiver Name: ______ **Preferred Phone:** ______

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

PRESCRIBER INFORMATION

Provider Name(s):

☐ ______ **DEA#:** ______ **NPI#:** ______

☐ ______ **DEA#:** ______ **NPI#:** ______

☐ ______ **DEA#:** ______ **NPI#:** ______

☐ ______ **DEA#:** ______ **NPI#:** ______

☐ ______ **DEA#:** ______ **NPI#:** ______

☐ ______ **DEA#:** ______ **NPI#:** ______

☐ ______ **DEA#:** ______ **NPI#:** ______

☐ ______ **DEA#:** ______ **NPI#:** ______

☐ ______ **DEA#:** ______ **NPI#:** ______

☐ ______ **DEA#:** ______ **NPI#:** ______

Practice Info:

Practice Name: ______

Address: ______

City, State: ______

Zip: ______ **Tax ID#:** ______

Phone: ______ **Fax:** ______

Key Contact: ______

Key Contact Phone: ______

Key Contact Email: ______

DIAGNOSIS/CLINICAL INFORMATION

(Please fax recent clinical notes, labs, tests, with the prescription to expedite the Prior Authorization)

Diagnosis: ______ **ICD-10:** ______

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Max. Daily Dosage	Sig	Qty.	Refills
☐					
☐					
☐					
☐					
☐					
☐					
☐					

PRESCRIBER SIGNATURE

Dispense as written ______ Date ______ Substitution Permissable ______ Date ______

Number of prescriptions: ______

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.
Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.