

**Patient Info Form  
Prescription**

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex:  Male  Female SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Insurance Information**

**Medical Benefits**

Primary Carrier: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group #: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Secondary Carrier: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Pharmacy Benefit Manager (PBM)**

PBM Name: \_\_\_\_\_  
 BIN #: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Member ID#: \_\_\_\_\_

\* NOTE: When available please attach copies of patient insurance or pharmacy card (front/back)

**Prescription**

Medication	Strength	Directions	Quantity	Refills

Syringes/Supplies:

Primary Dx: \_\_\_\_\_ Stage: \_\_\_\_\_ ICD-9: \_\_\_\_\_ Secondary Dx: \_\_\_\_\_ ICD-9: \_\_\_\_\_  
 Patient Weight: \_\_\_\_\_ lbs. Patient Height: \_\_\_\_\_ BSA: \_\_\_\_\_ Allergies: \_\_\_\_\_

**Physician Information**

Physician Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone: \_\_\_\_\_ State License#: \_\_\_\_\_ DEA#: \_\_\_\_\_ UPIN#: \_\_\_\_\_ NPI#: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ (required by law)

Prescription will be filled with generic unless prescriber writes "daw" (dispense as written) in the box:

**Shipping Instructions**

Ship to:  Physician's Office  Patient's Home  Home Care Agency: (name and address if available) \_\_\_\_\_  
 Ambulatory Infusion Center: (location address) \_\_\_\_\_  
 Date Required: \_\_\_\_\_ Preferred Delivery Time: \_\_\_\_\_  AM  PM