

McKESSON

Empowering Healthcare

McKesson Specialty Pharmaceuticals
5712 Jarvis Street
New Orleans, LA 70123-2222

INJECTABLE DRUG REQUEST FORM

FAX TO: 1-888-591-8482

Customer Service Phone: 1-888-456-7274

Date Needed: _____ (MM / DD / YY)

PRESCRIPTION

PATIENT INFORMATION:

| | | | | |
|---|----------------|-------|--|---|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yy): | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Patient Address: (include apt. #) | | City: | State: | Zip: |
| Daytime Phone: | Evening Phone: | | Best time to contact patient: <input type="checkbox"/> Morning <input type="checkbox"/> Evening | |
| Emergency Contact name, # relationship: | | | Primary Language: | |

INSURANCE INFORMATION: PLEASE SEND COPIES OF BOTH SIDES OF PHARMACY AND MEDICAL INSURANCE CARDS WITH THIS FORM.

| | | |
|---------------------------|----------------|--|
| Insured's Name: | Insured's SSN: | Insured's Employer or Group #: |
| Medical Insurance Name: | Medical ID#: | Medical Insurance Phone: |
| Pharmacy InsuranceName: | Pharmacy ID#: | Pharmacy Insurance Phone: |
| Secondary Insurance Name: | Secondary ID#: | Secondary Insurance Phone: |
| Prior Authorization: | Valid Through: | Is the patient Medicare primary? <input type="checkbox"/> Y <input type="checkbox"/> N |

PRESCRIPTION INFORMATION: If attaching an Rx, please include the ICD-9 code and physician signature.

| | | |
|---|----------------------------|---------------------|
| Drug: | Dose: _____ mg | Quantity: |
| Sig: | Stop Date: | Refill _____ months |
| ICD-9 Code: | Physician Signature: _____ | |
| <input type="checkbox"/> Generic substitution allowed <input type="checkbox"/> Dispense as written | | |

SHIPPING INFORMATION:

| Ship to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home (no PO Boxes please) <input type="checkbox"/> Other: _____ | Height: _____ / Weight: _____ Allergies (including food): _____ Current Medication Profile: (include OTCs & herbals) <table border="1"><thead><tr><th>Drug</th><th>Dose</th><th>Directions</th></tr></thead><tbody><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr></tbody></table> | Drug | Dose | Directions | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
|--|---|------------|------|------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Drug | Dose | Directions | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |

PHYSICIAN INFORMATION: If physician's shipping or billing addresses are different, please attach on a separate sheet.

| | | |
|---|-------------------------|---------------|
| Physician Name: | Specialty: | |
| Physician Address (include all suite, bldg. #'s, etc.): | | |
| Contact Name: | Phone # (include ext.): | Secure Fax #: |
| Physician UPIN #: | License #: | DEA #: |

All refrigerated prescriptions are shipped standard overnight service. Orders are shipped for delivery by the "Date Needed" noted above. Saturday delivery requires approval from a pharmacist. Contact for refill coordination is made prior to the due date.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.