SENT BY:

NEW PRESCRIPTION REQUEST

Please provide a written, signed prescription so that we can provide the medication to the patient or to your office.

Please complete all fields to ensure a timely delivery

Specialty Pharmacy
P.O. Box 509075
San Diego, CA 92150-9075
Phone: 866-218-7398 Fax: 800-853-3844
www.RxSolutions.com

PrescriptionSolutions
A UnitedHealth Group Company

Patient Information				Physician Information		
Patient Name				Prescribing Physician		DEA #
Member ID#				Primary Care Physician		
Address				Specialty		NPI #
City	State	Zip		Address		
Sex	Home Phone			City	State	Zip
DOB	Allergies			Office Phone	Office Fax	
Height/Weight **REQUIRED FOR GROWTH HORMONE REQUESTS**				Contact Person		

PRESCRIPTION (one request per form)

℞ ICD-9 Code _____ DATE _____

DRUG

SIG:

QUANTITY _____ REFILLS _____

PHYSICIAN SIGNATURE_____

☐ Dispense Brand Name _____
MD initials

Delivery Information			
Date Needed	☐ Patient	☐ Physician Office	☐ Other