

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](http://www.RxSolutions.com)



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 <b>**REQUIRED FOR GROWTH HORMONE REQUESTS**</b>				Contact Person		

### PRESCRIPTION (one request per form)

R<sub>x</sub>

ICD-9 Code \_\_\_\_\_

DATE \_\_\_\_\_

DRUG

SIG:

QUANTITY \_\_\_\_\_

REFILLS \_\_\_\_\_

PHYSICIAN

SIGNATURE \_\_\_\_\_

Dispense Brand Name \_\_\_\_\_  
MD initials

Delivery Information			
Date Needed	<input type="checkbox"/> Patient	<input type="checkbox"/> Physician Office	<input type="checkbox"/> Other

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