



General Use Fax Form
 Prescription/Pharmacy Intake Form
 Fax: 866.203.6010 Phone: 888.216.6710

PATIENT INFORMATION	<input type="checkbox"/> NEW TO THERAPY	<input type="checkbox"/> THERAPY CONTINUATION
Name: _____	<input type="checkbox"/> M <input type="checkbox"/> F	Daytime Phone w/Area Code: _____
Address: _____		Evening Phone w/Area Code: _____
City: _____ State: _____ ZIP Code: _____		Cell Phone w/Area Code: _____
DOB: _____ Patient Weight: _____ Patient Height: _____		PCP Name: _____
Allergies: _____		PCP Phone w/ Area Code: _____
Deliver medication to: <input type="checkbox"/> Patient's home <input type="checkbox"/> Prescriber's office	Date needed: _____	E-mail: _____

INSURANCE INFORMATION (Please include copy of front and back of insurance card if possible):

Provider/Plan: _____	Phone w/Area Code: _____
Patient's ID #: _____	Patient's Group #: _____
Policyholder's Name (if not patient): _____	
Secondary Insurance: _____	Phone w/Area Code: _____
Patient's ID #: _____	Patient's Group #: _____
Policyholder's Name (if not patient): _____	

CLINICAL CRITERIA **REQUIRED Please check all that apply. (Fill in condition(s) when necessary)**

ICD-9 and Condition: <input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Medication	Form	Strength	Dose	Qty	Directions/Freq	Refills

Print Prescriber's Name: _____ Office Contact: _____
 Practice Name: _____ State License #: _____
 UPIN: _____ NPI: _____ DEA # _____
 Address: _____ City: _____ State: _____ ZIP Code: _____
 Phone w/Area Code: _____ Fax w/Area Code: _____

Substitution Permissible.* In order for a brand-name product to be dispensed, the prescriber must handwrite BRAND NECESSARY or BRAND MEDICALLY NECESSARY in the space below.

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature Required: _____ Date: _____

CONFIDENTIAL HEALTH INFORMATION: Health care information is personal information related to a person's health care. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.
 IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

Drug names are the property of their respective owners.
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