Prescription Fax Order Form

PATIENT INFORMATION

Patient's Name ______________________ DOB (MM/DD/YYYY) ____________

Street Address ______________________

City/State/Zip ______________________ Email ____________

Allergies ______________________ Phone ____________

PRESCRIBER INFORMATION

Prescriber ______________________ Office Contact Name ____________

NPI# ______________________ DEA# ____________

Address ______________________

City/State/Zip ______________________

Phone ______________________ Fax ____________

Medication	Strength	Directions	Qty	Refill
Histex PD Drops **NDC: 28595-0809-30**	**Triprolidine HCl 1.25 mg**	**1 teaspoonful (5 mL) every 4-6 hours, not to exceed 4 teaspoonfuls (20 mL) in 24 hours** ALT Sig:	**1 fl oz (30 mL)** QTY:	**1** **2** **3** **4**

ICD-10 and Diagnosis ______________________

Prior Medication Trials/Failures (treatment name, duration, and reason for discontinuation) ______________________

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Commercial Insurance Information

Member Name (cardholder) ______________________ Rx Plan Name ____________

Prescription Drug Card Member ID# ______________________ Rx Group ____________

Rx BIN ______________________ Rx PCN ____________

Prescriber Signature ______________________ Date ____________

Transmitted by (Full Name) ______________________ Fax ____________

Write-In Rx

DISCLAIMER: By signing this form, I hereby authorize a capable and licensed pharmacy (the "pharmacy") to dispense and deliver all prescriptions as prescribed by my physician and to bill my insurance accordingly. I consent to have the pharmacy to contact me accordingly when my prescriptions are ready for refill. I understand that I may opt out of this service at any time. I also understand that the billing of my insurance does not guarantee payment and I may still be subject to financial responsibility including deductibles, copayments and any other payment required by my insurance plan. I further agree to be contacted by text or email at the provided number and email address if necessary and may opt out at any time. I understand that communications sent by text message over an open network or by unencrypted email are inherently unsecure, and there is no assurance of confidentiality of information communicated in this manner. I am aware that additional text message fees may apply. Nevertheless, I wish to communicate by email and text messages if I have provided my contact information and accept full responsibility for emails and/or text messages sent to or from this address or number. I am free to use any other pharmacy provider of my choice. I am not obligated to use this service.

Patient Signature ______________________ Date ____________

**This form is intended for office and clinic use only. This is not to advertise or promote claims of efficacy for any formulations.*

Disclosure Statement: You are free to use any other pharmacy provider you choose. You are not obligated to use this service.