For assistance, contact your pharmacy representative:	Phone:	(For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).



Universal

Prescription/Pharmacy Intake Form

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Pharmacy:									
Pharmacy Fax: Date Needed:	Chin T	Drogoriborio Of	ffice Deticated	Pharmacy	Phone:				
	•	0: Prescribers of	ilice 🗆 Patietit S F	nome 🗆 Other:					
PATIENT INFORMATI	ION								
Patient name:					DOB:	□Mal	e □Female		
Address:									
City:				State	2:	Zip code:			
					g):				
				•				_	
ID #:	Policy/Gro	DITE ATIO DACK OF CAL	u)	Phone #:		□ Patient is elic	aible for Medic	are	
Name of Insured:	1 Oloy Group #			_ Employer:					
Relationship to Patient: S	Self □ Other:			_ Prescription Card: □Y	es No Carrier:	Policy/Group #:			
Will there be access to anap	phylactic medication	is and oxygen at the	administration sit	e?					
CLINICAL ASSESSMI	ENT – Please c	omplete ALL se	ctions to avoi	id delays in filling pr	escription.				
☐ Patient is new to therapy	□ Patient is res	tarting therapy	Datient is current	ly on therapy Start	date:				
Primary Diagnosis Code an	d Condition (ICD-10)):	ir alient is current	lly on therapy Start	Date	e of Diagnosis:			
Other Diagnosis/Conditions	:								
Current Weight:	.□Ib □kg Date:		Current He		lcm Date:				
Other Therapies Tried &									
Allergies:									
PRESCRIPTION INFO	RMATION								
Medication	Form	Strength	Quantity	Directions/Freque	ncy		Dose	Refills	
								1	
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Louthoriza bu mu aigna	tura balaw tha dia	noncing of opprop	rioto noodloo one	d ouringse in a sufficien	t acceptity, required for the e	dministration of injectable	o producto bu	notiont or	
caregiver. Authorization					t quantity, required for the a	uministration of injectable	e products by	patient or	
	• • • • • • • • • • • • • • • • • • • •	concurrently with	ine namber of re	inis or time traine specif	ica for the drug.				
PRESCRIBER INFOR	MATION								
Prescriber's name:				_ Practice/facility:					
Address:				_ City:	State:	Zip code:			
Office contact:				_ Phone:					
				Best time to call:	Preferred	method of contact: □Emai	il □Phone □I	ax	
State license #:					Medicaid UPIN				
					and Medically Necessary" or the best of my knowledge. Pre				
Signature. Feetility that the a	ibove incrapy is me	arearry necessary arr	a aiat aic iiiiOiIIIa	mon above is accurate to t	no bost of my knowledge. Fle	somen s signature required		III IC3 DEIUW.	
Di.	co oc written			C. d444. 41			Data		
Dispen	se as written			Substitution per	milled	Ĺ	Date		

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information hat is legally protected. This information is intended only for the use of the individual or entity maned above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.