General
Prescription Referral Form
ESCRIBE #: 5700174
Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont Specialty Pharmacy

www.rosemontspecialtyrx.com

ACHC ACCREDITED urac ACCREDITED Specialty Pharmacy Expires 01/01/2020

1. Patient Information

Patient Name:	SSN:	DOB:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: ☐Male ☐Female	Height:	Weight: ☐ lbs. ☐ kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD-10:

4. Prescription Information: For IV medications attach a copy of your prescription

Medication	Dose/Strength	Max. Daily Dosage	Sig/Directions	Qty.	Refills
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					

Ship to: ☐ Patient ☐ Office ☐ Other

4. Physician Information:

INJECTION TRAINING: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Prescriber NPI:	DEA#:	
Address:	City:	State:	Zip:
Tax ID#:	Primary Office Contact:		
Fax Number:	Phone Number:	Office Contact Email:	

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.