General **Prescription Referral Form**

ESCRIBE #: 5700174 Phone: 1.877.592.7988 Fax: 1.800.787.0874







Sex: ☐ Male ☐ Female Height: 2. Insurance Information:		City: ☐ Ibs. ☐ kg.	SN: Email Address: Known Allergi	State:	DOB: Zip:	
Home Phone: Cell F Sex: □Male □Female Height: 2. Insurance Information:	Weight: ards (Prescription a	□ Ibs. □ kg.			Zip:	
Sex: ☐ Male ☐ Female Height: 2. Insurance Information:	Weight: ards (Prescription a			٥ς،		
2. Insurance Information:	ards (Prescription a		. Known Allergi	۵¢۰		
				cs.		
Please fay front and back conviof all Incurance of						
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 w	ith the prescriptior	n to expedite th	ne Prior Authorization			
Diagnosis:			ICD-10:			
4. Prescription Information: For IV medications attach a copy of your prescription						
						<u></u>
Medication Dose/Str	-	*	Sig/Directions		Qty.	Refills
	Dosa	ige				
Ship to : ☐ Patient ☐ Office ☐ Oth	ier					
4. Physician Information: INJECTION TRAINING: ☐ Office to Instruct ☐ SP to Arrange Teaching						
Prescriber Name:	Prescribe	r NPI:	<u> </u>	DEA	. #:	
Address:	City	;	State	e:	Zip:	
Tax ID#:		Primary Office	e Contact:			
Fax Number: Phone Number: Office Contact Email:						
*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initiate 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						
Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information that the properties of the properties of the properties of the transmitted material. Thank you. This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.						