AFREZZA
Prescription Referral Form
Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont Specialty Pharmacy

www.rosemontspecialtyrx.com

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: AFREZZA	Dose/Strength	Sig/Directions	Qty.	Refills
☐ 4 Unit Cartridges	Includes 360 Total Afrezza Insulin Units	Inhale _____units per meal. Use Additional _____units as needed Total Daily Units:_____	# of Packs _____	Ref8ills: #_____ 30 days____ 90 days____
☐ 8 Unit Cartridges	Includes 720 Total Afrezza Insulin Units	Inhale _____units per meal. Use Additional _____units as needed Total Daily Units:_____	# of Packs _____	Refills: #_____ 30 days_____ 90 days_____
☐ 12 Unit Cartridges	Includes 1080 Total Afrezza Insulin Units	Inhale _____units per meal. Use Additional _____units as needed Total Daily Units: _____	# of Packs _____	Refills: #_____ 30 days ____ 90 days ____
☐ 4 & 8 Units Titration Pack	Includes 1080 Total Afrezza Insulin Units	Inhale _____units per meal. Use Additional _____units as needed Total Daily Units: _____	# of Packs _____	Refills: #_____ 30 days ____ 90 days ____
☐ 4, 8 & 12 Units Titration Pack	Includes 1440 Total Afrezza Insulin Units	Inhale _____units per meal. Use Additional _____units as needed Total Daily Units: _____	# of Packs _____	Refills: #_____ 30 days ____ 90 days ____
☐ 8 & 12 Units Combo Pack	Includes 1800 Total Afrezza Insulin Units	Inhale _____units per meal. Use Additional _____units as needed Total Daily Units: _____	# of Packs _____	Refills: #_____ 30 days ____ 90 days ____

Ship to: ☐ Patient ☐ Office ☐ Other

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.