PHONE (877) 592-7988 FAX (800) 787-0874

Escribe Number: 5700174

**Standing Order for Therapeutic Interchange**

Upon receipt of a written order from (*Practice name and all prescribing HCPs*), and its affiliate located at (ADRESS OF FACILITY OR DR OFFICE ) Rosemont Specialty Pharmacy will have the authority to make therapeutic interchange according to the following:

If for whatever reason the patient cannot purchase the medication prescribed (due to lack of insurance, high copay/deductible, or similar reasons), the prescribing physician and/or Rosemont pharmacist may interchange the drug therapy to provide relief of cost while maintaining therapeutic equivalence.

**NSAID:**

Primary Choice: Nsaid Name 0.00% - ML\_\_\_ REFILLS: \_\_#\_\_

*Instill* *\_1\_ drop(s) into affected eyes \_#\_ times daily.*

Second Choice: Nsaid Name 0.00% - #ML\_\_\_ REFILLS: \_\_#\_\_

*Instill* *\_1\_ drop(s) into affected eyes \_#\_ times daily.*

Third Choice: Nsaid Name 0.00% - #ML\_\_\_ REFILLS: \_\_#\_\_

*Instill* *\_1\_ drop(s) into affected eyes \_#\_ times daily.*

**STEROID:**

Primary Choice: Steroid 0.00% - # ML\_\_\_\_\_\_\_\_\_ REFILLS: \_\_#\_\_

*Instill* *\_1\_\_ drop(s) into affected eyes \_#\_ times daily.*

Second Choice: Steroid 0.00% - # ML\_\_\_\_\_\_\_\_\_ REFILLS: \_\_#\_\_

*Instill* *\_1\_\_ drop(s) into affected eyes \_#\_ times daily.*

Third Choice: Steroid 0.00% - # ML\_\_\_\_\_\_\_\_\_ REFILLS: \_\_#\_\_

*Instill* *\_1\_\_ drop(s) into affected eyes \_#\_ times daily.*

**ANTIBIOTIC:**

Primary Choice: Antibiotic 0.00% - # ML\_\_\_\_\_\_\_\_\_ REFILLS: \_\_#\_\_

*Instill* *\_1\_\_ drop(s) into affected eyes \_#\_ times daily.*

Second Choice: Antibiotic 0.00% - # ML\_\_\_\_\_\_\_\_\_ REFILLS: \_\_#\_\_

*Instill* *\_1\_\_ drop(s) into affected eyes \_#\_ times daily.*

Third Choice: Antibiotic 0.00% - # ML\_\_\_\_\_\_\_\_\_ REFILLS: \_\_#\_\_

*Instill* *\_1\_\_ drop(s) into affected eyes \_#\_ times daily.*

The prescriber(s) may override this agreement if they deem it necessary for specific patients, and any and all therapeutic interchange will be discussed with the patient prior to dispensing to the patient. Therapy changes will be documented in accordance to prescribers’ wishes.

**Prescriber:**

Name: \_Dr. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI:

Name: \_Dr. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI:

Name: \_Dr. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI:

Name: \_Dr. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI:

Name: \_Dr. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI:

Name: \_Dr. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI:

Name: \_Dr. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI: 

Name: \_Dr. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI: 

Name: \_Dr. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI: 

Office Contact Person: Phone Ext Email

Fax

Address:

Please fax completed form to **(800) 787-0874 / 407-822-1921.**