

FAX FORM TO: 1.866.233.8317

PHONE: 1.855.492.0817

EMAIL: contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION	
Name: _____	
Address: _____	
City, State, ZIP: _____	
Primary Phone: - - DOB: / /	
Alternate Phone: - - Gender:	
Email: _____	
Primary Language: _____	Last Four of SSN: _____

2. PRESCRIBER INFORMATION	
Name: _____	
DEA #: _____	NPI #: _____ State Lic. #: _____
Group or Hospital: _____	
Address: _____	
City, State, Zip: _____	
Phone: - - Fax: - -	
Contact Person: _____	Phone: - -

3. INSURANCE INFORMATION *Fax copy of prescription and insurance cards with this form, if available (front and back)*

Primary Insurance Company Name: _____	Secondary Insurance Company Name: _____
Primary Cardholder Name: _____	Secondary Cardholder Name: _____
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent
Phone: - - Member ID: Group #:	Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: Patient Office Other:

Date of Diagnosis: / /

ICD-10 Code	Description	Pregnancy Category: <input type="radio"/> Adult female of childbearing potential <input type="radio"/> Adult female not of childbearing potential <input type="radio"/> Female child of childbearing potential <input type="radio"/> Female child not of childbearing potential <input type="radio"/> Adult male <input type="radio"/> Male child	Allergies:	
				Other Conditions:
				Other Medications:
				Previous Therapies:

Height (in/cm): _____ Weight (lb/kg): _____ BSA (m²): _____

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X _____ / / X _____ / /

DISPENSE AS WRITTEN DATE PRODUCT SUBSTITUTION PERMITTED DATE

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