

Patient Name First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ DOB \_\_\_\_\_ Weight \_\_\_\_\_  Male  Female  
 Street Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Daytime Tel \_\_\_\_\_ Evening Tel \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_  
 Ship to Patient at  Home  Work **OR** Patient will pick up at  Physician Office  Pharmacy Date Needed \_\_\_\_\_  
 ICD-10 Code \_\_\_\_\_ Diagnosis \_\_\_\_\_ Duration of treatment From \_\_\_\_\_ To \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Eligible for Medicare  Yes  No If yes, Medicare# \_\_\_\_\_  
 Prescription Card  Yes  No If Yes, Carrier \_\_\_\_\_ Tel \_\_\_\_\_ Fax \_\_\_\_\_ Policy/Group# \_\_\_\_\_  
 Bin# \_\_\_\_\_ Pcn# \_\_\_\_\_ RXID# \_\_\_\_\_ RX Group# \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Office Contact \_\_\_\_\_  
 Street Address \_\_\_\_\_ Suite # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Tel \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
 License# \_\_\_\_\_ NPI# \_\_\_\_\_ UPIN# \_\_\_\_\_ DEA# \_\_\_\_\_

## PRESCRIPTION

## PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

### FRAGMIN

2,500 units/0.2ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 5,000 units/0.2ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 7,500 units/0.3ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 10,000 units/1ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 12,500 units/0.5ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 15,000 units/0.6ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 18,000 units/0.72ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_

### LOVENOX

30mg/0.3ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 40mg/0.4ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 60mg/0.6ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 80mg/0.8ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 100mg/1ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 120mg/0.8ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 150mg/1ml Syringe \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_

### ARIXTRA

2.5mg/0.5ml Vial \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 7.5mg/0.6ml Vial \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 10mg/0.8ml Vial \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_

### HEPARIN SODIUM

5,000 units/0.2ml Vial \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_  
 10,000 units/0.2ml Vial \_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_

### OTHER

\_\_\_\_\_ QTY \_\_\_\_\_ Refill X \_\_\_\_\_

By signing this form and utilizing our services, you are authorizing Med Center Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

**Prescriber's Signature** (signature required. NO STAMPS) \_\_\_\_\_ **Date** \_\_\_\_\_

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