



**PATIENT INFORMATION**

*(Complete the following or include demographic sheet)*

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Country: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_  Home  Cell  Work  
 DOB: \_\_\_\_\_ Gender:  Male  Female  
 E-mail: \_\_\_\_\_  
 Primary Language: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber's Name: \_\_\_\_\_  
 License #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 DEA #: \_\_\_\_\_  
 Group or Hospital: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State Zip: \_\_\_\_\_  
 Country: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**INSURANCE INFORMATION** Please fax copy of prescription and insurance cards with this form, if available (front and back)

**DIAGNOSIS AND CLINICAL INFORMATION**

**Diagnosis: (ICD-9 or ICD-10)**

Please include diagnosis name and code:

ICD9 or ICD10	Description

**Additional Clinical Information:**

Therapy:  New  Reauthorization  Restart

Height: \_\_\_\_\_ in/cm

Weight: \_\_\_\_\_ kg/lbs

Allergies: \_\_\_\_\_

Concomitant Medications: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Has patient received injection training?  Yes  No  N/A

**PRESCRIPTION INFORMATION**

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Patient is interested in patient support programs

Prescriber's Sig \_\_\_\_\_

Date: \_\_\_\_\_

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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