# PRESCRIPTION FORM

| PATIENT INFORMATION | | PRESCRIBER INFORMATION | |
|---|---|---|---|
| PATIENT NAME: | | PRESBRIBER NAME: | |
| DATE OF BIRTH: | GENDER: M / F | SPECIALTY: | |
| SSN: | | ADDRESS: | |
| ADDRESS: | | | |
| | | PHONE: | |
| PHONE: | | FAX: | |
| | | DEA: | NPI: |

| INSURANCE INFORMATION | | | CURRENT PHARMACY INFORMATION |
|---|---|---|---|
| INSURANCE PLAN NAME: | | | PHARMACY NAME: |
| RX BIN: | RX GROUP: | | CITY, STATE: |
| ID: | | | PHONE: |
| MEDICARE ☐ | MEDI-CAL ☐ | COMMERCIAL ☐ | FAX: |

## PRESCRIPTION INFORMATION

| | | |
|---|---|---|
| EDARBI® [azilsartan medoxomil] | ☐ **EDARBI 40MG**<br>SIG: TAKE 1 TABLET BY MOUTH ONCE DAILY ____________<br>QTY☐30 TABS☐90 TABS REFILLS____ | ☐ **EDARBI 80MG**<br>SIG: TAKE 1 TABLET BY MOUTH ONCE DAILY ____________<br>QTY☐30 TABS☐90 TABS REFILLS____ |
| EDARBYCLOR® (azilsartan medoxomil/chlorthalidone) | ☐ **EDARBYCLOR 40/12.5MG**<br>SIG: TAKE 1 TABLET BY MOUTH ONCE DAILY ____________<br>QTY☐30 TABS☐90 TABS REFILLS____ | ☐ **EDARBYCLOR 40/25MG**<br>SIG: TAKE 1 TABLET BY MOUTH ONCE DAILY ____________<br>QTY☐30 TABS☐90 TABS REFILLS____ |

## CLINICAL INFORMATION

DIAGNOSIS (SELECT ALL THAT APPLY) ☐ Essential (Primary) Hypertension (I10)

☐ Hypertensive chronic kidney disease (I11) ☐ Hypertensive heart and chronic kidney disease (I13)

OTHER DIAGNOSIS ________________________________ __________________________ ______________________________

**PLEASE SELECT ALL THE MEDICATIONS THE PATIENT HAS A FAILURE, INTOLERANCE, CONTRAINDICATION TO:**

| ACE Inhibitors | ARB's | Beta Blockers | Calcium Channel Blockers | Diuretics |
|---|---|---|---|---|
| ☐ BENAZEPRIL | ☐ ATACAND | ☐ ATENOLOL | ☐ AMLODIPINE | ☐ HZTC |
| ☐ ENALAPRIL | ☐ COZAAR | ☐ METOPROLOL | ☐ DILTIAZEM | ☐ METOLAZONE |
| ☐ LISINOPRIL | ☐ BENICAR | ☐ PROPANOLOL | ☐ NIFEDIPINE | ☐ BUMETANIDE |
| ☐ RAMIPRIL | ☐ MICARDIS | ☐ ACEBUTOLOL | ☐ VERAPAMIL | ☐ FUROSEMIDE |
| ☐ FOSINOPRIL | ☐ DIOVAN | ☐ NADOLOL | ☐ FELODIPINE | ☐ AMILORIDE |
| | | | | |

## **PLEASE FAX A COPY OF PRESCRIPTION, LABS, PROGRESS NOTES**

SUPPORTING STATEMENT (COMMENTS, SYMPTOMS, AND WHY OTHER MEDICATIONS WOULD NOT BE APPROPRIATE)

______________________________________________________________________________

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______________________________________________________________________________

______________________________________________________________________________

By signing below, the prescriber gives consent to **Orange Plaza Pharmacy to act as the prescriber's agent** to begin and execute the prior authorization process, as well as to help the patient apply to co-pay assistant programs (including coupons, foundations and manufacturer assistance programs if necessary). The prescriber certifies that the information is true, accurate and the requested services are medically necessary to the health of the patient.

**PRECRIBER SIGNATURE: ______________________________________DATE:___________** ☐DO NOT SUBSTITUTE

**Newport Lido Pharmacy Phone: 949-764-6580**

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