BURBANK SPECIALTY PHARMACY
201 S Buena Vista St Ste 110 Burbank, CA 91505

FAX REFERRAL: (818)563-3011
Phone: (818)563-2120

LINZESS REFERRAL FORM

PATIENT INFORMATION (Complete the following or send patient demographic sheet)	**PRESCRIBER INFORMATION**
Patient Name:	Prescriber's Name:
Address:	Contact Person:
City, State, Zip:	Phone:
Phone:	Fax:
Date of Birth	DEA:

Please fax copy of insurance card (Front & Back)	
Linzess □ **145 mcg cap , #30** □ **290 mcg cap , #30** **Directions: 1 cap daily**	

PRESCRIBER SIGNATURE: _____ DATE: _____

Need By: _____ **Ship To:** □ **Patient** □ **Office** □ **Patient Pick-up**