BURBANK SPECIALTY PHARMACY	**Phone: 818-563-2120** Fax: 818-563-3011 or 818-563-2130

Patient Name:	Today's Date:
DOB SSN	Prescriber:
Home Phone Work/Other Phone	Phone Number Fax Number
Home Address	Address
Shipping Address (If different from home address)	Office Contact: Prefers: □ Fax □ Phone □ E-mail _____
Language Preference: □ English □ Spanish □ Other _____	Ship to: □ Home □ MDO NEED CLASS_____

Rx: VIBERZI

TAPE PRESCRIPTION HERE PRIOR TO FAXING **OR** COMPLETE THE FOLLOWING:

□ **Viberzi 100mg** One 100 mg tablet 2 times a day with food **Qty: _____ Refill x _____**
□ **Viberzi 75mg** One 75 mg tablet 2 times a day with food **Qty: _____ Refill x _____**

Physician Signature: _____ DEA: _____