



*Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.*

**PATIENT INFORMATION**

Deliver Here

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_ Gender:  Male  Female

Email: \_\_\_\_\_

Last 4# of SS: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Deliver Here

Name: \_\_\_\_\_

State License #: \_\_\_\_\_ NPI: \_\_\_\_\_

DEA #: \_\_\_\_\_ Tax ID \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION** If available, please fax copy of prescription insurance cards with this form (front and back).

**PRESCRIPTION**

Diagnosis/Clinical Information *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: \_\_\_\_\_

ICD-10: \_\_\_\_\_

**Pulmozyme® (dornase alfa)** SIG:Dose: \_\_\_\_\_ mg for inhalation using recommended nebulizer

Frequency \_\_\_\_\_ Dispense Quantity: \_\_\_\_\_ Re-ills: \_\_\_\_\_

NKDA

Known Drug Allergies \_\_\_\_\_

**Tobi® (tobramycin)** SIG:Dose: \_\_\_\_\_ mg for inhalation using recommended nebulizer

Frequency \_\_\_\_\_ Dispense Quantity: \_\_\_\_\_ Re-ills: \_\_\_\_\_

NKDA

Known Drug Allergies \_\_\_\_\_

Deliver to: Physician Office \_\_\_\_\_ Patient Home \_\_\_\_\_

**PATIENT SUPPORT PROGRAMS:** Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Physician Signature: \_\_\_\_\_

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

Dispense as written

Date

Substitution Permissible

Date

I authorize Medical Center Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: \_\_\_\_\_

There are 1 of 4 options for you when finding our company: 1. NPI # - 1821395609, 2. NCPDP # - 5640289

3. Company Name: Community Medical Center Pharmacy, 4. Company Address: 610 Gateway Center Way, San Diego, CA 92102

