


PRESCRIPTION FORM

PATIENT INFORMATION			PRESCRIBER INFORMATION		
PATIENT NAME:			PRESCRIBER NAME:		
DATE OF BIRTH:		GENDER: M / F	SPECIALTY <input type="checkbox"/> PAIN MANAGEMENT <input type="checkbox"/> ONCOLOGY <input type="checkbox"/> PALLIATIVE CARE <input type="checkbox"/> OTHER: _____		
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 <input type="checkbox"/>	MEDI-CAL <input type="checkbox"/>	COMMERCIAL <input type="checkbox"/>	FAX:		
PRESCRIPTION INFORMATION					
MEDICATION		DIRECTIONS			QTY -REFILLS
<input type="checkbox"/>	VIVLODEX® 5MG	_____			_____
<input type="checkbox"/>	VIVLODEX® 10MG	_____			_____
<input type="checkbox"/>	ZORVOLEX® 18MG	_____			_____
<input type="checkbox"/>	ZORVOLEX® 35MG	_____			_____
<input type="checkbox"/>	TIVORDEX® 20MG	_____			_____
<input type="checkbox"/>	TIVORDEX® 40MG	_____			_____
CLINICAL INFORMATION					
DIAGNOSIS (SELECT ALL THAT APPLY) <input type="checkbox"/> M19.90 OSTEOARTHRITIS <input type="checkbox"/> G89.2 CHRONIC PAIN <input type="checkbox"/> G89.3 NEOPLASM RELATED BREAKTHROUGH PAIN <input type="checkbox"/> OTHER DIAGNOSIS: _____					
PLEASE SELECT ALL THE MEDICATIONS THE PATIENT HAS A FAILURE, INTOLERANCE, CONTRAINDICATION TO:					
PAIN RELIEVER					
IBUPROFEN		MELOXICAM		VOLTAREN	
NAPROXEN		ASPIRIN		CAPSAICIN	
TRAMADOL		OXYCODONE		PIROXICAM	
DICLOFENAC		ACETAMINOPHEN		PREDNISONE	
CELECOXIB		INDOMETHACIN		FENTANYL	
HYDROCODONE/APAP		ETODOLAC		MORPHINE	
PLEASE ATTACH COPY OF PRESCRIPTION, LABS, PROGRESS NOTES					
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.					
PRESCRIBER SIGNATURE: _____ DATE: _____ DO NOT SUBSTITUTE					
			Orange Plaza Pharmacy Phone: 714-550-9798 1010 W. La Veta Ave. Suite 130 Orange, CA 92868 Fax: 714-550-9336		