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** SIG: TAKE 1 TABLET BY MOUTH ONCE DAILY QTY☐30 TABS☐90 TABS REFILLS____	☐ **EDARBI 80MG** SIG: TAKE 1 TABLET BY MOUTH ONCE DAILY QTY☐30 TABS☐90 TABS REFILLS____
EDARBYCLOR® (azilsartan medoxomil/chlorthalidone)	☐ **EDARBYCLOR 40/12.5MG** SIG: TAKE 1 TABLET BY MOUTH ONCE DAILY QTY☐30 TABS☐90 TABS REFILLS____	☐ **EDARBYCLOR 40/25MG** SIG: TAKE 1 TABLET BY MOUTH ONCE DAILY 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)

_____

_____

_____

_____

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

ORANGE PLAZA PHARMACY

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