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

ELIQUIS® (apixaban)

☐ ELIQUIS 2.5MG
DIRECTIONS: _____
QTY _____REFILLS_____

☐ ELIQUIS 5MG
DIRECTIONS: _____
QTY _____REFILLS_____

CLINICAL INFORMATION

DIAGNOSIS	SELECT MEDICATIONS THE PATIENT HAS A
☐ **ATRIAL FILIBRILATION (I48.1)**	FAILURE, INTOLERANCE, CONTRAINDICATION:
DOES THE PATIENT HAVE AN BIOPROSTHETIC HEART VALVE? **YES NO**	☐ PRADAXA® (DABIGATRAN)
DOES THE PATIENT HAVE AN MECHANICAL PROSTHETIC HEART VALVE? **YES NO**	☐ COUMADIN® (WARFARIN)
☐ **DEEP VEIN THROMBOSIS (I82.409) PULMONARY EMBOLISM (I26.99)**	☐ XARELTO® (RIVAROXABAN)
HAS THE PATIENT BEEN TREATED WITH AN ANTICOAGULANT? **YES NO**	☐ _____
☐ **PROPHOLAXIS OF VENOUS THROMBOEMBOLISM (VTE) AFTER ORTHOPEDIC SURGERY?**	
DOES THE PATIENT HAVE A COMPLETION OF TOTAL KNEE OR HIP REPLACEMENT SURGERY? **YES NO**	
☐ **OTHER DIAGNOSIS_____ICD 10 CODE_____**	
IS THE MEDICATION BEING USED AS A CONTINUATION OF THERAPY UPON HOSPITAL DISCHARGE? YES NO	

PLEASE ATTACH 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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