PRESCRIPTION FORM

PATIENT INFORMATION			PRESCRIBER INFORMATION
PATIENT NAME:			PRESBRIBER NAME:
DATE OF BIRTH: GENDER: M / F			SPECIALTY ☐ PAIN MANAGEMENT ☐ONCOLOGY ☐ PALLIATIVE CARE ☐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 ☐	MEDI-CAL ☐	COMMERCIAL ☐	FAX:

PRESCRIPTION INFORMATION

MEDICATION	DIRECTIONS	
☐ **DUEXIS ® 800MG-26.6MG**	TAKE 1 TABLET BY MOUTH THREE TIMES DAILY	# 90
☐ ***VIMOVO* ® 500MG-20MG**	TAKE 1 TABLET BY MOUTH TWICE DAILY	# 60
☐ ***VIMOVO* ® 375MG-20MG**	TAKE 1 TABLET BY MOUTH TWICE DAILY	# 60
☐ ***ZIPSOR* ® 25MG**	TAKE 1 CAPSULE BY MOUTH FOUR TIMES DAILY	# 120

CLINICAL INFORMATION

DIAGNOSIS (SELECT ALL THAT APPLY) ☐ M19.90 OSTEOARTHRITIS ☐ G89.2 CHRONIC PAIN
☐ G89.3 NEOPLASM RELATED BREAKTHROUGH PAIN ☐ OTHER DIAGNOSIS:_____

PLEASE SELECT ALL THE MEDICATIONS THE PATIENT HAS A FAILURE, INTOLERANCE, CONTRAINDICATION TO:

PAIN RELIVER				**PROTON PUMP INHIBITOR**	
IBUPROFEN		MELOXICAM		OMEPRAZOLE	
NAPROXEN		ASPIRIN		LANZOPRAZOLE	
TRAMADOL		OXYCODONE		PANTOPRAZOLE	
DICLOFENAC		ACETAMINOPHEN		ESOMEPRAZOLE	
CELECOXIB		HYSINGLA		DEXLANSOPRAZOLE	
HYDROCODONE/APAP		PERCOCET		RABEPRAZOLE	

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.

PRECRIBER SIGNATURE: _____DATE:_____ DO NOT SUBSTITUTE

ORANGE PLAZA PHARMACY

Orange Plaza Pharmacy **Phone: 714-550-9798**

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