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

☐ _____

☐

DIRECTIONS: _____

QTY _____ *REFILLS* _____

CLINICAL INFORMATION

DIAGNOSIS	SELECT MEDICATIONS THE PATIENT HAS A FAILURE, INTOLERANCE, CONTRAINDICATION:
☐	☐
☐	☐
☐	☐
IS THE MEDICATION BEING USED AS A CONTINUATION OF THERAPY? **YES** **NO**	

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

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

1010 W. La Veta Ave. Suite 130 Orange, CA 92868 **Fax: 714-550-9336**