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Patient Prescription Form
Specialty Pharmacy Program
- CONFIDENTIAL -

Please complete and fax to one of the following dispensing pharmacies:

Caremark Specialty Pharmacy Services	**CuraScript, Inc.**	**Accredo Health Group**	**Walgreens Specialty Pharmacy**
Phone: 1-800-237-2767	Phone: 1-888-773-7376	Phone: 1-888-239-0725	Phone: 1-888-347-3416
Fax: 1-800-323-2445	Fax: 1-888-773-7386	Fax: 1-866-387-1003	Fax: 1-877-231-8302

Physician Information

Physician's Name:
Address:
City:
State: Zip:
Office Contact:
Telephone:
Fax:
NPI #:
State License #:
DEA #:

Patient Information

Patient's Name:
Address:
City:
State: Zip:
Date of Birth: / / Sex: ❑ M ❑ F
Social Security #:
Daytime Telephone #:
Evening Telephone #:
Height: Weight:
Allergies:

Primary Insurance Information

Insured's Name:
Relationship:
ID #:
Policy #:
Carrier/Group #:

Other Insurance Information

Insurance Company:
Policy #:
Group #:
Insured's Name:
Relationship:
Social Security #:
Date of Birth: / /

Clinical Information

Diagnosis Code: _____ Primary Diagnosis: _____

Prescription Medications	**Strength**	**Directions (Dose/Route/Frequency)**	**Quantity/Length**
1)			
2)			
3)			
4)			

# of Refills: _____ **Physician's Signature:** _____ **Date:** _____ **DAW:** _____

Delivery Instructions

Ship to: ❑ Physician's Office
❑ Patient's Home
❑ Other
Delivery Date: Refill Date:

If Other, please supply:
Address:
City:
State: Zip:

G0-590 (10.09)

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