

Date Shipment Needed:	Ship To: □Patient □Prescriber
□Nursing needed □Training needed ► All the supplies inclu	iding syringes and needles will be dispensed if needed.

Phone: 833.442.8911 • F	Fax: 833.271.4659	וכו וופום ם	EFERRAL FO) PM			
PATIENT INFORMATION	N	IOLUGIO N		∠13(¥)			
Patient Name:	IN		DOB:	Sov: □M	I □F Weight:		□lbs. □kg.
SSN:	Phone:	Allergies:	IDOB.	Sex. 💷	i 🗕 r vveigitt.		Laibs. Laky.
Address:	Phone.	Allergies.	City	Ctoto		Zip:	
		Dhono	City:	State:			information
Emergency Contact:	ATION	Phone:			□Please attach o	iemographic	information
PRESCRIBER INFORMA	ATION	NPI:		DEA:		State Lic:	
Prescriber: Supervising Physician:		JINPI.	Practice Nam			State Lic.	-
Address:			City:	e. State:		Zip:	-
Phone:	Fax:		Key Office Co		Phone:	[Ζίμ.	
	TION / MEDICAL ASSESMENT		rkey Office Co	miaci.	Trilone.		
Primary Diagnosis: (ICD							
	ted previously for this condition		. ,				
Is patient currently on	therapy? Yes No Medic	ation(s):					
 Will patient stop taking 	g the above medication(s) befo	re starting the new medication	on? □Yes □N	o If yes:			
	ent wait before starting the new			•			
	being prescribed for blast pha		ves please call	ΔcariaHealth to alert th	ne pharmacy of the	urgency	
	tient is currently taking including					urgericy.	
- Other medications pa	tient is currently taking including	g OTO medications with dos	age and direction	n (or lax medication pi	oille).		
INSURANCE INFORMATION	TION						
	nd back of patient's insurance	a card (medical and prescr	intion)				
COPAY CARD ENROLL		cara (medicar and presci	iption)				
□Please check if enroll		/ ID:					
PRESCRIPTION INFORI		ID.					
TRECORD HOW IN OR	MATION						
lclusig [®] 山 10 mg table	et □15 mg tablet □30 mg t	tablet 4 5 mg tablet					
Directions						OTV	Defiller
Directions.						QTY:	_ Refills:

Prescriber's Signature: DAW (Dispense as Written)

Date: _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription electronically or on

official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.