MEMORIAL HERMANN Specialty Pharmacy

GENERAL PRESCRIPTION REFERRAL FORM

Please sign and fax completed form to 713.704.3841
If you have questions, please call 281.698.6100

SHIP TO: ☐ PATIENT ☐ OFFICE - FIRST DOSE ☐ OFFICE - ALL DOSES ☐ OTHER

1 PATIENT INFORMATION

☐ Male ☐ Female

Patient Name: _____ DOB: _____
Street Address: _____
City, State, ZIP: _____
Primary Phone: _____ Alt. Phone: _____
Email Address: _____
Patient's primary language: _____

Please attach front and back copy of ALL insurance cards

2 PRESCRIBER INFORMATION

☐ MD ☐ DO ☐ NP ☐ PA

Prescriber Name: _____
Specialty: _____ NPI #: _____
Office Contact: _____ DEA #: _____
Email: _____ Preferred Method of Contact
Phone: _____ Fax: _____ ☐ Email ☐ Phone ☐ Fax
Office Address: _____
City, State, ZIP: _____

3 CLINICAL INFORMATION

Diagnosis (ICD-10)

Primary ICD: _____ Description: _____
Other ICD: _____ Description: _____

Treatment History

Patient is treatment: ☐ Naive ☐ Experienced
If treatment-experienced, medications tried/failed with dates: _____

Medical Information

Allergies: _____
Current weight: _____ kg Date: _____
Current height: _____ cm Date: _____
Other medications patient is taking including OTC, with dose and directions. *May fax medication profile separately.* _____

4 PRESCRIPTION INFORMATION

Date Medication Needed: _____ Patient requires injection training by pharmacy: ☐ Yes ☐ No

MEDICATION	STRENGTH	FORMULATION	DIRECTIONS	QTY	REFILLS

By signing below, I authorize Memorial Hermann Specialty Pharmacy and its representatives to serve as my designated agent, if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies.

Prescriber's Signature (signature required - NO STAMPS)**:** _____ **Date:** _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** on the prescription.