CareMed
SPECIALTY PHARMACY

Faxed prescriptions can only be accepted from a prescribing practitioner.
e-prescribe - **NPI# 1659380772 or NCPDP # 3306986**

Pharmacy 877.227.3405
Fax 877.542.2731

# General Rx Order Form

## Patient Information (REQUIRED)

Date: ____________________

Patient Name: ____________________ Date of Birth: ____________ Sex: ☐ M ☐ F Last 4 Digits of SSN: ____________

Address: ____________________ City: ____________ State: ______ Zip: ______

Home Ph: ____________ Cell Ph: ____________ Email: ____________________

Patient Weight: ________ lbs. Patient Height: ________ Date Taken: ____________ Allergies: ____________________

## Pharmacy Benefit Manager (REQUIRED) Please provide copies of both sides of the patient's card(s)

PBM Name: ____________________ Rx BIN# ____________ PCN#: ____________

Rx Group#: ____________________ Member ID#: ____________________

## Medical/Health Insurance Info. (REQUIRED) Please provide copies of both sides of the patient's card(s)

Primary: ____________ Policy Holder: ____________ Policy # ________ Ph: ________

Address: ____________________ City: ____________ State: ________ Zip: ________

Secondary: ____________ Policy Holder: ____________ Policy # ________ Ph: ________

Address: ____________________ City: ____________ State: ________ Zip: ________

## Current Medication List

____________________________________________

____________________________________________

RX PRESCRIPTION

| Medication | Strength | SIG: Directions | Quantity | Refills |
|---|---|---|---|---|
| | | | # ________ ☐ Tablets ☐ Capsules | |

ADMINISTRATION SUPPLIES

| Quantity | Description | Refills |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

DIAGNOSIS INFORMATION

## Diagnosis Information (For PA & Funding Support) Please include a complete list of medications and prior therapies with this order

Primary Dx: ____________________ Dx Date (needed for funding) ____________ ICD-10: ____________

Secondary Dx: ____________________ Dx Date (needed for funding) ____________ ICD-10: ____________

REQUIRED PHYSICIAN INFO.

## Physician Information

Prescriber name: ____________________ Contact: ____________________

Email: ____________________ Street: ____________________ City: ____________

State: ____________ Zip: ____________ Ph: ____________ Fax: ____________ NPI #: ____________

Tax ID # (needed for funding): ____________ Prescriber Signature (required by law): ____________________ Date: ________

Prescription will be filled with generic unless prescriber writes "DAW" (dispense as written) in the box ☐

SHIPPING

## Shipping Instructions

Ship to: ☐ Physician's Office ☐ Patient's Home ☐ Other ____________________ Date Required: ____________

*State law for MO/NY/OH/VA/VT allows only 1 medication per order form. Please use a new form for additional medications.*

CM-813 3.22