HPC SPECIALTY PHARMACY

General Prescription Referral Form

Field Contact:

PATIENT INFORMATION

Patient Name: _____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Physical Address: _____
City: _____ State: _____ Zip: _____

Phone: (____) - ____ - _____ Emerg. Contact: _____
Email: _____ Emerg. Phone: (____) -____ -_____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: ____ /____ / ____
Allergies: Medications: *(Please attach additional pages if necessary)*

PRESCRIPTION BENEFITS INFORMATION *(Please attach front and back of insurance card)*

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____
Clinic/Hospital Affiliation: _____

Phone: (____) - ____ - _____
Fax: (____) - ____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

CLINICAL CONSIDERATIONS

Diagnosis: _____

ICID10: _____

℞ PRESCRIBING INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills

Injection Training

Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

PRESCRIBER SIGNATURE *(Stamp signature not allowed, physician signatured required)*

_____ _____ _____

Product Selection Permitted **Dispense as Written** **Date**

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____

PHONE: 1-800-757-9192
www.hpcinfusion.com

PLEASE INCLUDE ALL MEDICAL RECORDS & LAB VALUES
PLEASE FAX TO 1-855-813-0583