

Specialty Referral

Referral for Medication and Patient Management Program



Phone: 877.385.0535

Fax: 877.326.2856

****Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents****

Patient Demographics		Provider Information	
Name _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F		Prescriber _____	
DOB _____ SSN _____		NPI _____ DEA _____	
Phone _____ 2 nd Phone _____		Practice Name _____	
Address _____ Apt/Suite _____		Address _____	
City, State, ZIP _____		City, State, ZIP _____	
Primary language, if other than English _____		Phone _____ Fax _____ Key contact _____	
This is a <input type="checkbox"/> New Rx <input type="checkbox"/> Refill	Training by <input type="checkbox"/> Prescriber's office <input type="checkbox"/> Pharmacy to facilitate <input type="checkbox"/> Not needed	Ship first fill to <input type="checkbox"/> Prescriber's office <input type="checkbox"/> Patient <input type="checkbox"/> Other _____	

Clinical Information	
Diagnosis (include ICD-10 code): _____	Weight _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Height _____ <input type="checkbox"/> in
Allergies _____	
Relevant Laboratory/Imaging Data _____	
Prior treatments & reason for discontinuation _____	
Other notes _____	

Medication	Dose	Directions	Quantity	Refills

Please note: To increase adherence and patient acceptance all medications will be dispensed as pen type injectors unless unavailable or otherwise specified.

Provider Signature _____ **Date** _____

My signature for this prescription confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies if necessary, in conjunction with the therapy prescribed above.

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