



Physician Drug Order
 Facsimile (866) 364-2673
 Customer Service (800) 775-5138

Patient Information Please type or print clearly.	Name		Date of Birth		Sex <input type="checkbox"/> F <input type="checkbox"/> M
	Address				
	City		State		Zip Code
	Home Phone		Cell Phone		Work Phone
	Emergency Contact		Phone		Relationship
	Shipping Address				

Health Conditions	Treatment Diagnosis				ICD-9 Code
	Other Health Conditions				
	Height	Weight	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Insulin Dependent	
	Allergies				

Insurance Information	Policy Holder Name			Policy Holder DOB
	INS ID #		Group #	

Delivery Instructions	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Physician's office <input type="checkbox"/> Other _____
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Prescription Orders IMPORTANT: Prescription must be faxed from a physician's office.	RX 1
	Sig: _____
	QTY: _____ Refills: _____ Estimated Start of Therapy: _____
	RX 2
Sig: _____	
QTY: _____ Refills: _____ Estimated Start of Therapy: _____	
OTHER RX OR INFORMATION: _____	

Physician Certification	I certify that the above therapy is medically necessary and the information above is accurate to the best of my knowledge.				
	Physician Signature (required)			Date	
	Print Physician Name			DEA #	
	Form Faxed by		NPI #		LIC #
	Address		City		State Zip Code
	Contact				
	Phone			Fax	