To: PHARMACY
Passion for Life

**Contact #: Toll Free Phone:** 866.413.3156
**Toll Free Fax:** 877.834.1231
**Fax:** 760.340.3258

**Conact name:** ______________________

**From:** ______________________

**Contact #:** ______________________

**Date:** ______________________

**Pages:** ________

# FAX COVER SHEET

## Patient Information

Patient name: ______________________ DOB: ____/____/____ ☐ Male ☐ Female

Address: ______________________ City: ______________ ST: _____ Zip: ________

Phone: ______________ Cell: ______________ E-mail: ______________

Social Security#: ______________________ Weight: ________ lb Height: ________ in

Allergies: ______________________ Date shipment needed: ____/____/____

Ship to: ☐ Patient ☐ Physician ☐ Other ______________ Patient education kit? ☐ Yes ☐ No

Teaching to be done at: ☐ Physician office ☐ Patient home (to be coordinated with River's Edge Pharmacy)

## Insurance Information

Insurance provider: ______________________
(please include copy of card)

ID #: ________ Policy group #: ________ PCN#: ________

Phone: ______________________

Name of insured: ______________________

Employer: ______________________

Relationship to patient: ☐ Self ☐ Other: ______________

Patient is eligible for Medicare Prescription Card: ☐ Yes ☐ No

Carrier: ______________ Policy group #: ______________

## Prescriber Information

Prescriber name: ______________________

State lic.: ______________________

DEA: ______________ NPI: ______________

Address: ______________________

City: ______________ ST: ________ Zip: ________

Phone: ______________ Fax: ______________

## Clinical Information

Diagnosis: ______________________

Prior tried & tailed medication: ______________________

Other: ______________________

## Prescription Information

Medication: ______________________

Dose: ________ Sig: ________ Maintenance: ________ Duration: ________

Other: ______________________

## Notes

By signing below, the prescriber gives consent to both, the prescription(S) above, as well as to River's Edge Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to Co-pay Assistance programs, including all foundations and manufacturer assistance programs if necessary.

**Prescriber Signature:** ______________________ **Date:** ____/____/____

***IMPORTANT NOTICE:*** *This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, recipient should immediately notify the sender at the address and telephone numbers set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone than the named addressee, except by express authorization of the sender to the named addressee.*



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