General Prescription Referral Form

HPC SPECIALTY PHARMACY
GEN_0109-1020

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.HPCSpecialtyPharmacy.com

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

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