



Prescription Request Form

Urgent Request

Fax: 909-284-9140
Phone: 909-266-0016

PRESCRIBER INFORMATION

Patient Name _____	Prescriber Name _____
Address _____	DEA _____
Address 2 _____	NPI _____
City, State, Zip _____	Address _____
Home Phone _____ Mobile Phone _____	City, State, Zip _____
DOB _____ Gender _____	Phone _____ Fax _____
	Contact Person _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Duexis Tablet (Ibuprofen 800mg/Famotidine 26.6mg) - Take 1 tablet by mouth 3 times a day			<input type="checkbox"/> 90 Tablets	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Pennsaid 2% – Apply 2 pumps to the affected area twice a day			<input type="checkbox"/> 112 Grams	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Rayos 5mg Tablet – Take _____ tablet(s) by mouth at bedtime with food			<input type="checkbox"/> 30 Tablets <input type="checkbox"/> 60 Tablets <input type="checkbox"/> 90 Tablets <input type="checkbox"/> _____ Tablets	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Rayos 2mg Tablet – Take _____ tablet(s) by mouth at bedtime with food			<input type="checkbox"/> 30 Tablets <input type="checkbox"/> 60 Tablets <input type="checkbox"/> 90 Tablets <input type="checkbox"/> _____ Tablets	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Rayos 1mg Tablet – Take _____ tablet(s) by mouth at bedtime with food			<input type="checkbox"/> 30 Tablets <input type="checkbox"/> 60 Tablets <input type="checkbox"/> 90 Tablets <input type="checkbox"/> _____ Tablets	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Vimovo Tablet	<input type="checkbox"/> Naproxen 375mg/Esomeprazole 20mg – Take 1 TAB PO BID <input type="checkbox"/> Naproxen 500mg/Esomeprazole 20mg – Take 1 TAB PO BID		<input type="checkbox"/> 30 Tablets	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Other				<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____

Ship to: Patient Office Other _____ Date: _____ Need by Date _____

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted Dispense as Written

Prescriber's Signature: _____ Date: _____

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