Prescription Request Form

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

Urgent Request

PRESCRIBER INFORMATION

Patient Name _____
Address _____
Address 2 _____
City, State, Zip _____
Home Phone _____ Mobile Phone _____
DOB _____ Gender _____

Prescriber Name _____
DEA _____
NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Contact Person _____

PRESCRIPTION INFORMATION

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

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: _____