

FAX FORM TO: 1.877.597.3070

PHONE: 1.800.473.3516

EMAIL: specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION	
Name: _____	
Address: _____	
City, State, ZIP: _____	
Primary Phone: - -	DOB: / /
Alternate Phone: - -	Gender: _____
Email: _____	
Primary Language: _____	Last Four of SSN: _____

2. PRESCRIBER INFORMATION	
Name: _____	
DEA #: _____	NPI #: _____ State Lic. #: _____
Group or Hospital: _____	
Address: _____	
City, State, Zip: _____	
Phone: - -	Fax: - -
Contact Person: _____	Phone: - -

3. INSURANCE INFORMATION		<i>Fax copy of prescription and insurance cards with this form, if available (front and back)</i>
Primary Insurance Company Name: _____		Secondary Insurance Company Name: _____
Primary Cardholder Name: _____		Secondary Cardholder Name: _____
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent		Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent
Phone: - -	Member ID: _____	Group #: _____

4. DIAGNOSIS AND CLINICAL INFORMATION			
Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:		
Date of Diagnosis: / /	Pregnancy Category: <input type="radio"/> Adult female of childbearing potential <input type="radio"/> Adult female not of childbearing potential <input type="radio"/> Female child of childbearing potential <input type="radio"/> Female child not of childbearing potential <input type="radio"/> Adult male <input type="radio"/> Male child	Allergies: _____	
ICD-10 Code		Description	Other Conditions: _____
			Other Medications: _____
			Previous Therapies: _____
Height (in/cm): _____ Weight (lb/kg): _____ BSA (m ²): _____			

5. PRESCRIPTION INFORMATION				
Medication	Dose/Strength	Directions	Quantity	Refills

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE	
X _____ / /	X _____ / /
DISPENSE AS WRITTEN	PRODUCT SUBSTITUTION PERMITTED
DATE	DATE

IMPORTANT NOTICE: This facsimile transmission 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, the recipient should immediately notify the sender at the address or telephone number 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 other than the named addressee, except by express authority of the sender to the named addressee.