

Date Needed: _____

Note: This form is intended for prescriber use only. If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

Patient Information			
Last Name	First Name		Date of Birth
		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Home Phone	Work or Mobile Phone	Email Address (Email used for order status updates)	
Address			
City		State	Zip Code

Patient Insurance Information	
Medical Insurance (Please include copy of front and back of card)	Prescription Card Phone
Subscriber Name	
Policy #	BIN/PCN #
Medicare Number	Medicaid Number
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Other _____	Prescription Card <input type="checkbox"/> Yes <input type="checkbox"/> No

Clinical Information			
Medicare Number		Medicaid Number	
Patient Weight _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg (check one)	Height _____	<input type="checkbox"/> Patient is New to Therapy <input type="checkbox"/> Patient is Restarting Therapy <input type="checkbox"/> Patient is Currently on Therapy (Start Date: _____)	
Allergies	Diagnosis	ICD-10	
Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Prescriber Office <input type="checkbox"/> Other _____			

IMPORTANT WARNING: This is intended for the use of the person or entity to whom it is addressed and contains sensitive, confidential information, the disclosure of which may be governed by federal and/or state law. If you are not the intended recipient, or responsible for delivering it to the intended recipient, you are hereby notified that any use, dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

Prescriber Information			
Prescriber Last Name	Prescriber First Name	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA	
Prescriber Address			
City		State	Zip Code
Phone	Fax	Backline Phone Number	
License #	NPI #	UPIN #	DEA #
Office Contact		Supervising Physician (if applicable)	

Prescription: Write prescription here and fax to MedImpact Direct Specialty.

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Patient's Name	Patient's Date of Birth

Prescriber's Signature

I certify that the therapy is medically necessary and that the information above is accurate to the best of my knowledge. I authorize MedImpact to act on my behalf as my agent for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient's benefit plan. **Prescriber's Signature Required:**

X _____ **X** _____
 Generic Substitution Permitted Dispense As Written

 Printed Name

Date: _____ **Hold shipment until notified by prescriber**

CONFIDENTIAL HEALTH INFORMATION: This form contains health information protected under federal and state confidentiality laws, including but not limited to the Health Insurance Portability and Accountability Act and its implementing regulations (HIPAA). I certify that I have received the appropriate authorization from the patient, if required, and met any other applicable requirements imposed under federal and/or state law, including but not limited to HIPAA, needed to send this information to MedImpact Direct Specialty HUB (MedImpact) and its contracted pharmacies for the purposes of verifying the patient's insurance coverage and providing information on appeals for denied claims.

Prescriber must manually sign (rubber stamps, signature by other office personnel for the prescriber, and computer generated signatures will not be accepted).