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Patient Prescription Form
Specialty Pharmacy Program
- CONFIDENTIAL -

Please complete and fax to one of the following dispensing pharmacies:

Caremark Specialty Pharmacy Services
Phone: 1-800-237-2767
Fax: 1-800-323-2445

Curascript, Inc.
Phone: 1-888-773-7376
Fax: 1-888-773-7386

Accredo Health Group
Phone: 1-888-239-0725
Fax: 1-866-387-1003

Physician Information

Physician's Name:
Address:
City:
State: Zip:
Office Contact:
Telephone:
Fax:
NPI #:
State License #:
DEA #:

Patient Information

Patient's Name:
Address:
City:
State: Zip:
Date of Birth: / / Sex: ○ M ○ F
Social Security #:
Daytime Telephone #:
Evening Telephone #:
Height: Weight:
Allergies:

Primary Insurance Information

Insured's Name:
Relationship:
ID #:
Policy #:
Carrier/Group #:

Other Insurance Information

Insurance Company:
Policy #:
Group #:
Insured's Name:
Relationship:
Social Security #:
Date of Birth: / /

Clinical Information

Diagnosis Code: Primary Diagnosis

	Prescription Medications	**Strength**	**Directions (Dose/Route/Frequency)**	**Quantity/Length**
1)				
2)				
3)				
4)				

# of Refills: **Physician's Signature:** **Date:** **DAW:**

Delivery Instructions

Ship to: ○ Physician's Office
○ Patient's Home
○ Other
Delivery Date: Refill Date:

If Other, please supply:
Address:
City:
State: Zip:

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