

PATIENT STATUS		PACKAGING	DELIVERY	
New Patient	Current Patient	Josef Compliance Packaging	Patient's home	Pharmacy pickup
New RX	Refill	Vials (Child Proof Yes No)	MD's office	1 st dose at MD's office and remaining refills at patient's home
Medicare/Medicaid				Date Needed:
Primary Caregiver:				

PATIENT INFO					PRESCRIBER INFO		
Last Name, First Name		Primary Language			Today's Date		
Best Phone Number ()		Alternate Phone Number ()			Physician Name		NPI #
Home Address		City, State	Zip		State License #		DEA #:
Shipping Address (if different from home address)					Address		City, State Zip
Social Security Number		Date of Birth			Phone Number ()		Fax Number ()
Height	Weight	BMI	Gender M F	Pregnant Yes No	Key Office Contact Name		Email

CLINICAL INFORMATION / STATEMENT OF MEDICAL NECESSITY

Diagnosis ICD-9 Diagnosis Date
 Please provide brief medical justification (previous treatments & dates, failed therapies, etc.) or fax/attach medical history.

Drug Allergies

Is patient currently in therapy? Yes No Medication(s)

Will patient stop taking the above medications before starting the new medication? Yes No

If yes, what is the washout period?

Other medication patient is currently taking including OTC medications or fax medication profile

PRESCRIPTION INFORMATION OR ATTACH RX

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS

I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies and to coordinate/receive patient lab values.

Patient is interested in Patient Support Programs as necessary/applicable

Ancillary kits and supplies provided as necessary/applicable

 Doctor/Prescriber Signature – Dispense as Written

 Date

 Doctor/Prescriber Signature – Substitution Permissible

 Date

**PLEASE FAX: 1) FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)
 3) CURRENT MEDICATION AND OTC PROFILE 4) MEDICAL HISTORY**

2) LABS