Enova Care
PHARMACY
Your Health in Safe Hands

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Prescription Referral Form

Send your Rx to: _____

Date Medication Needed: _____ Ship To: (○) Patient's Home (○) Prescriber's Office

1. Patient Information | Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Date of Birth: _____ Sex: (○) Male (○) Female Height: _____ Weight: _____ ( ) lbs. ( ) kg.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Alternate Caregiver Name: _____ Preferred Phone: _____

2. Prescriber Information

Provider's Name: _____ Specialty: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Body Weight: _____ lb/Kg Age: _____ Adult/Pediatric: _____

Diagnosis:

☐ ICD-10
☐ ICD-10
☐ ICD-10
☐ ICD-10

Lab Work:

☐ ☐ _____
☐ ☐
☐ ☐

History / Current Medical Status:

☐ Uncontrolled BP - BP record: _____
☐ Seizures disorder - Specify: _____
☐ Pregnant / Nursing: _____
☐ Heart disease - Specify: _____
☐ Stroke / DVT / PT: _____
☐ Bleeding Disorder - Specify: _____
☐ Any Allergy - Specify: _____
☐ Patient been previously on any ESA Therapy? (○) Yes (○) No
Drug Name: _____ For how long?: _____

4. Treatment Plan

☐ Insurance Cards ☐ History & Physical ☐ Most Recent Labs ☐ Medication List

5. Prescription Information

Drug Name	Strength	Dose / Frequency / Route	Refill

6. Premedication

☐ Include premedication per The Medicine Shoppe infusion protocol.
☐ Others

☐ CBC every
☐ CMP every
☐ Others

_____ _____ _____ _____
Dispense as written **Date** **Substitution Permissible** **Date**

# of Prescriptions: _____