

Toll Free: 877.977.9118

Patient Information

Toll Free Fax: 800-550-6272

Ship To: Patient Physician/Clinic Date Shipment Needed: _____ **Rx:** New Refill _____

Date: _____ Patient SS#: _____ Male Female Childbearing Female
 Patient's First Name: _____ Patient's Last Name: _____
 Address: _____ City/County: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 DOB: _____ Patient's Weight: _____ lbs. Recorded Date: _____
 Allergies: _____ Diagnosis/ ICD9 Code: _____


Insurance Information (fill out entirely OR fax copy of patient's insurance card - both sides and patient face sheet)

Primary Insurance: _____ Secondary Insurance: _____
 Insured: _____ Insured: _____
 Phone: _____ Phone: _____
 Policy#: _____ Group#: _____ Policy#: _____ Group#: _____

PATIENT NAME _____ **AGE** _____

ADDRESS _____

_____ **DATE** _____



Gelclair
6 boxes (1350ml) = 30 day supply
TID or PRN

PHYSICIAN'S SIGNATURE _____

ADDRESS _____

DEA NO. _____ **REFILL** _____ **TIMES**

Physician's Name: (please print) _____ Contact Person: _____
 Phone Number: _____ Fax Number: _____
 Office Address: _____ City: _____ State: _____ Zip: _____
 License# _____ NPI# _____ UPIN# _____ MEDICAID Provider# _____
 Physician's signature: _____ M.D. DEA# _____
I authorize Diplomat Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.