Publix Specialty Pharmacy #3213

PRESCRIPTION REFERRAL FORM

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐Male ☐Female Caregiver Name:_____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical Information: [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐No ☐Yes

Primary Diagnosis: _____ Diagnosis code: _____

Secondary Diagnosis: _____ Diagnosis code: _____

Treatment status: ☐New to therapy ☐Continuation of therapy, start date: ____/_____/_____ Is the patient on samples? ☐Yes ☐No

Allergies: ☐ NKDA ☐Other: _____ Weight: _____☐kg ☐lb, Height: _____☐cm ☐in

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS

Prescriber Information

Ship to prescriber: ☐ Never ☐Always ☐First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable ☐ _____ Supervising Physician NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted) _____ _____

☐Substitution allowed Date ☐Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here: