Publix Specialty Pharmacy #3213 PRESCRIPTION REFERRAL FORM

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

Patient's First Name:			Patient's Last Name:				
			Caregiver Name:				
			City:				
Primary Phone Number:	()		Alt. Phone Number: ()			
Clinical Information: [Attach copy of labs and clinical notes]			□ Urgent Request	Using Cover My Meds: \Box No \Box Yes			
Primary Diagnosis:Secondary Diagnosis:Treatment status: New to therapy Continuation of therapy, star				Diagn	Diagnosis code:		
			t date://	Is the			
Allergies: 🗆 NKDA 🗆 🛛	Other:			Weight:	$_$ kg \Box lb, Height: _	$_$ cm \square in	
MEDICATION	DOSE/STRENGTH		DIRECTIONS		DISPENSE QTY/DA	YS REFILLS	
Prescriber Information	Ship to prescriber:	Never 🗆 Always 🛛	□ First fill only	Appointme	ent date:/	/	
Name:			DEA#	NPI	#		
			Superv				
Address:							
			: ()				
I authorize Publix Pharn	nacy representatives to a	ict on behalf of the j	prescriber to initiate and con	nplete the ins	surance prior authorizat	ion process.	
Prescriber's				For st	ates requiring hand writt	en expressions	
signature:				to pre	event substitution, write h	iere:	
(stamps not \Box Substitut	tion allowed Date	e Dispense as v	written/ Do not substitute D	Date			

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accepted)