Prescriber Order Form

Fax: 877.265.9119
Phone: 800.540.4700

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alt Phone: _____

Emergency Contact Name and Phone: _____

Weight: _____ ☐ lbs ☐ kg Allergies: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS

PRESCRIBER ORDERS

☐ _____

_____

_____

☐ _____

_____

_____

☐ Verbal order received from: _____

Pharmacist Name: _____

Pharmacist Signature: _____ Date: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA

License #: _____ NPI: _____ DEA#: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____

PRESCRIBER SIGNATURE

(Prescriber, please and date below)

No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.

Prescriber Signature – Substitution Permissible	Date	Prescriber Signature – Dispense as Written	Date

I authorize Polaris Specialty Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including submission of any necessary forms to such health plans.

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