Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to pharmacy.

Specialty Referral

Referral for Medication and Patient Management Program

OptiMed

Phone: 877.385.0535
Fax: 877.326.2856

Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents

Patient Demographics

Name _____ Sex ☐M ☐F

DOB _____ SSN _____

Phone _____ 2nd Phone _____

Address _____ Apt/Suite _____

City, State, ZIP _____

Primary language, if other than English _____

Provider Information

Prescriber _____

NPI _____ DEA _____

Practice Name _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____ Key contact _____

This is a ☐ New Rx ☐ Refill

Training by ☐ Prescriber's office ☐ Pharmacy to facilitate ☐ Not needed

Ship first fill to ☐ Prescriber's office ☐ Patient ☐ Other _____

Clinical Information

Diagnosis (include ICD-10 code): _____ **Weight** _____ ☐ lb ☐ kg **Height** _____ ☐ in

Allergies _____

Relevant Laboratory/Imaging Data _____

_____

Prior treatments & reason for discontinuation _____

_____

_____

_____

Other notes _____

_____

_____

Medication	Dose	Directions	Quantity	Refills

Please note: To increase adherence and patient acceptance all medications will be dispensed as pen type injectors unless unavailable or otherwise specified.

Provider Signature _____ **Date** _____

My signature for this prescription confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies if necessary, in conjunction with the therapy prescribed above.

V121919A

CLEAR FORM