

Date Needed: _____

Note: This form is intended for prescriber use only. If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

| Patient Information | | | | |
|---------------------|----------------------|---|---------------|---|
| Last Name | First Name | | Date of Birth | Gender <input type="checkbox"/> M <input type="checkbox"/> F |
| Home Phone | Work or Mobile Phone | Email Address (Email used for order status updates) | | |
| Address | | | | |
| City | | State | Zip Code | |

| Patient Insurance Information | |
|---|--------------------------|
| Medical Insurance (Please include copy of front and back of card) | Prescription Card Phone |
| Subscriber Name | |
| Policy # | BIN/PCN # |
| Medicare Number | Medicaid Number |
| Relationship to Patient Self Other _____ | Prescription Card Yes No |

| Clinical Information | | | |
|---|--------------|--|--|
| Medicare Number | | Medicaid Number | |
| Patient Weight _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg (check one) | Height _____ | <input type="checkbox"/> Patient is New to Therapy <input type="checkbox"/> Patient is Restarting Therapy <input type="checkbox"/> Patient is Currently on Therapy (Start Date: _____) | |
| Allergies | Diagnosis | ICD-10 | |
| Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Prescriber Office Other _____ | | | |

IMPORTANT WARNING: This is intended for the use of the person or entity to whom it is addressed and contains sensitive, confidential information, the disclosure of which may be governed by federal and/or state law. If you are not the intended recipient, or responsible for delivering it to the intended recipient, you are hereby notified that any use, dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

| Prescriber Information | | | |
|------------------------|-----------------------|---------------------------------------|-----------------------------------|
| Prescriber Last Name | Prescriber First Name | MD | DO <input type="checkbox"/> NP PA |
| Prescriber Address | | | |
| City | | State | Zip Code |
| Phone | Fax | Backline Phone Number | |
| License # | NPI # | UPIN # | DEA # |
| Office Contact | | Supervising Physician (if applicable) | |

Prescription: Write prescription here and fax to MedImpact Direct Specialty.

| | |
|----------------|-------------------------|
| <hr/> | |
| Patient's Name | Patient's Date of Birth |

Prescriber's Signature

I certify that the therapy is medically necessary and that the information above is accurate to the best of my knowledge. I authorize MedImpact to act on my behalf as my agent for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient's benefit plan. **Prescriber's Signature Required:**

X _____ **X** _____
 Generic Substitution Permitted Dispense As Written

 Printed Name

Date: _____ **Hold shipment until notified by prescriber**

CONFIDENTIAL HEALTH INFORMATION: This form contains health information protected under federal and state confidentiality laws, including but not limited to the Health Insurance Portability and Accountability Act and its implementing regulations (HIPAA). I certify that I have received the appropriate authorization from the patient, if required, and met any other applicable requirements imposed under federal and/or state law, including but not limited to HIPAA, needed to send this information to MedImpact Direct Specialty HUB (MedImpact) and its contracted pharmacies for the purposes of verifying the patient's insurance coverage and providing information on appeals for denied claims.

Prescriber must manually sign (rubber stamps, signature by other office personnel for the prescriber, and computer generated signatures will not be accepted).