

## **GENERAL REFERRAL ENROLLMENT & PRESCRIPTION FORM**

**PHONE**: 800-641-8475 **FAX**: 800-530-8589 **WEB**: www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

|                          | Patient: Caregiver:   |                         |   |                       |         |  |
|--------------------------|---|-------------------------|---|-----------------------|---------|--|
| PATIENT<br>FORMATION     |   |                         | lbs (check one) Height: in o                                |                       |         |  |
|                          | Address: City:  |                         |   |                       |         |  |
|                          | Best Phone #: Cell Alternate Phone #:   |                         |   |                       |         |  |
| P. OFN                   | Allergies: Latex Allergy: Yes No  |                         |   |                       |         |  |
|                          | ICD-10 Code for requested therapy: ICD-10 Code(s) for other medical conditions:   |                         |   |                       |         |  |
|                          |   |                         |   |                       |         |  |
|                          | PLEASE FAX COP  | Y OF ALL INSURANCE CA   | RDS (FRONT & BACK) INCLUDING INFORMATION INCLUDING LAB RESU | MEDICAL AND PRESCRIPT | ION.    |  |
|                          | FEEASE  | PROVIDE ALL CLINICAL II | TORMATION INCLUDING LAB RES                                 | JEIS ON ALL FORMS.    |         |  |
|                          |   |                         |   |                       |         |  |
|                          | MEDICATION  | DOSE/STRENGTH           | DIRECTIONS  | QTY                   | REFILLS |  |
|                          |   |                         |   |                       |         |  |
|                          |   |                         |   |                       |         |  |
|                          |   |                         |   |                       | DA14/   |  |
|                          |   |                         |   |                       | DAW:    |  |
| PRESCRIPTION INFORMATION |   |                         |   |                       |         |  |
|                          |   |                         |   |                       |         |  |
|                          |   |                         |   |                       |         |  |
|                          |   |                         |   |                       | DAW:    |  |
|                          |   |                         |   |                       |         |  |
| RM/                      |   |                         |   |                       |         |  |
| NF0                      |   |                         |   |                       |         |  |
| I NO                     |   |                         |   |                       | DAW:    |  |
| PTI(                     |   |                         |   |                       |         |  |
| CRI                      |   |                         |   |                       |         |  |
| RES                      |   |                         |   |                       |         |  |
| Δ.                       |   |                         |   |                       | DAW:    |  |
|                          |   |                         |   |                       |         |  |
|                          |   |                         |   |                       |         |  |
|                          |   |                         |   |                       |         |  |
|                          |   |                         |   |                       | DAW:    |  |
|                          |   |                         |   |                       |         |  |
|                          |   |                         |   |                       |         |  |
|                          |   |                         |   |                       |         |  |
|                          |   |                         |   |                       | DAW:    |  |
|                          |   |                         |   |                       |         |  |
|                          | INJECTION TRAINING: OFFICE TO COORDINATE HEALTHDYNE SPECIALTY TO COORDINATE   |                         |   |                       |         |  |
|                          | Anticipated Start Date: Prescriber Specialty:   |                         |   |                       |         |  |
| ION                      | Ship to: Patient Physician Clinic Other:  |                         |   |                       |         |  |
| ESCRIBER INFORMATION     | Fax #: Contact Name:  |                         |   |                       |         |  |
|                          | Office Address:   |                         |   |                       |         |  |
| N N                      | The terms and conditions posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by          |                         |   |                       |         |  |
| BER                      | reference. The data privacy terms posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by |                         |   |                       |         |  |
| CRIE                     | reference. I understand that HealthDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.         |                         |   |                       |         |  |
| SES(                     | , ,   |                         | , , ,   | ·                     |         |  |
| <del>,</del>             | Prescriber's Name:  | F                       | rescriber's Signature:                                      | Date: _               |         |  |

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Dispense as written

Use substitution