PRESCRIPTION REQUEST FORM

PATIENT INFORMATION	PRESCRIBER INFORMATION
Last Name, First Name	Today's Date DEA #
SSN	Prescriber Name NPI #
Home Phone Number Other Phone Number	Address City, State Zip
Home Address City, State Zip	Phone Number Fax Number Email
Shipping Address (if different from home address)	Name of Office Contact
	Preferred Contact Method (check one) O Email O Phone O Fax

COMPLETE BELOW OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

INSURANCE		
Rx ID		
RXGRP#	RXBIN#	RXPCN#

CLINICAL INFORMATION
Drug allergies (if applicable):

PRESCRIPTION	
Rx	DRUG:
	SIG:
QTY:_____	REFILLS:_____ SHIP TO: HOME____ OFFICE____
Prescriber Signature: DATE:_____/ _____/ _____	

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

Please FAX completed prescription order to WeCare Specialty Pharmacy at 540-878-5048.
516 Fletcher Drive, Warrenton, Va 20186 / Info@WeCarePharm.com/ Phone: 540-422-2968