



Please complete and fax this form to (866) 936-8206.

phone (650) 412-4530
email pharmacy@alphascriptrx.com
web www.alphascriptrx.com

Prescription Referral Form

Patient Information

Name: Birthdate: Sex: M F Weight:
Known allergies:
Address, City, State, ZIP:
Preferred Phone: Email:
Authorized Representative/Caregiver Name: Authorized Representative/Caregiver Phone:

Please fax front and back of all insurance cards.

Prescriber Information

Name: DEA#: NPI#:
Facility Name:
Address, City, State, ZIP:
Nurse/Key Contact: Phone: Fax:
Nurse/Key Contact Email:

Diagnosis/Clinical Information

Diagnosis/ICD-10:

Please fax recent clinical notes, labs, tests, etc. with the prescription to expedite the Prior Authorization.

Prescription Information

Table with 5 columns: Medication, Dose/Strength, Sig, Qty., Refills

Prescriber Signature

Dispense As Written (Signature/Date)

Substitution Permissable (Signature/Date)

Do not use this form to prescribe controlled substances. All information provided herein is confidential and intended for the sole use of Alphascript, Inc. All messages and attached information are protected from disclosure by law.