ALPHAscript

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

Medication	Dose/Strength	Sig	Qty.	Refills

Prescriber Signature

Dispense As Written (Signature/Date)

Substitution Permissable (Signature/Date)