

Send updates to: Fax: _____ Email: _____ Text: _____

Physician Information

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA		NPI:
Office Contact:		Practice name/Supervising MD:		
Address:		City:		
State:	Zip:	Phone:	Fax:	

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:
Policyholder Name:	Policyholder DOB:	BIN: PCN:

Medical History | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

Has patient been treated previously for this condition? <input type="radio"/> Y <input type="radio"/> N	Medication(s):
Is patient currently on therapy? <input type="radio"/> Y <input type="radio"/> N	Medication(s):
Will patient stop taking the above medication(s) before starting the new medication? <input type="radio"/> Y <input type="radio"/> N	If Yes How long should patient wait before starting the new medication?
Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):	
Primary Diagnosis: (ICD-10/Diagnosis Code & Description)	
TREATMENT ARRANGEMENTS: Ship Meds: <input type="radio"/> Home <input type="radio"/> Doctor's Office	

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				

By signing this form and utilizing our services, you are authorizing Aureus and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____	Date _____	Physician Signature: _____	Date _____
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Substitution Permitted

Dispense as Written