1405 Jefferson Hwy Suite A
New Orleans, LA 70121
Phone: (504)842-7439
1-855-312-4193
Fax: (504)842-5999
www.ochsnerspecialtypharmacy.com

General

PATIENT INFORMATION:

Patient Name:____________________________________
Date of Birth:_____________Male:☐ Female:☐
Address:____
City/State/Zip:____________________________________
Tel:____________________Alt Tel:__________________
SS#:____________________Wt:_________Ht:_________
NKDA:☐ Allergy:______________________________

INSURANCE INFORMATION:

Primary Pharmacy Insurance________________________
Member Name_______________________________
Member ID:______________________________________
Rx Group #:______________________________________
BIN#________________PCN#______________________
Customer Service #:________________________________
Please attach a copy of the front and back of the patient's insurance card, if available.**

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis and ICD10:______________________________________
Prior meds failed:____

PRESCRIBER INFORMATION:

Prescriber Name:____Specialty:_________________________________
Address:____City/State/Zip:_____________________________
Contact Name:____________________Phone #:_____________________________Fax #:__________________________
NPI#:____________________________DEA #:_____________________________UPIN #:_________________________

By signing this form and using our services, you are authorizing Ochsner Specialty Pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Printed Name:_______________________________________ Date:__________________________

Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**) ____

____ ____

Substitution Allowed *Dispense as Written*

PRESCRIPTION:

Medication	Strength	Directions	Quantity	Refills