CareMed SPECIALTY PHARMACY

Pharmacy 877.227.3405 Fax 877.542.2731
Faxed prescriptions can only be accepted from a prescribing practitioner.
e-prescribe - NPI# 1659380772 or NCPDP# 3306986

Xuriden® 2 g
(uridine triacetate)
Oral Granules

Prescription Order Form

Patient Information (REQUIRED)

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F Last 4 Digits of SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Email: _____

Patient Weight: _____ lbs. Patient Height: _____ Date Taken: _____ Allergies: _____

Pharmacy Benefit Manager (REQUIRED) Please provide copies of both sides of the patient's card(s)

PBM Name: _____ Rx BIN# _____ PCN#: _____

Rx Group#: _____ Member ID#: _____

Medical/Health Insurance Info. (REQUIRED) Please provide copies of both sides of the patient's card(s)

Primary: _____ Policy Holder: _____ Policy # _____ Ph: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary: _____ Policy Holder: _____ Policy # _____ Ph: _____

Address: _____ City: _____ State: _____ Zip: _____

Current Medication List

_____

_____

RX PRESCRIPTION

Medication	Strength	SIG: Directions	Quantity	Refills
			# _____ ☐ Tablets ☐ Capsules	

ADMINISTRATION SUPPLIES

Quantity	Description	Refills

DIAGNOSIS INFORMATION

Diagnosis Information (For PA & Funding Support) Please include a complete list of medications and prior therapies with this order

Primary Dx: _____ Dx Date (needed for funding) _____ ICD-10: _____

Secondary Dx: _____ Dx Date (needed for funding) _____ ICD-10: _____

REQUIRED PHYSICIAN INFO.

Physician Information

Prescriber name: _____ Contact: _____

Email: _____ Street: _____ City: _____

State: _____ Zip: _____ Ph: _____ Fax: _____ NPI #: _____

Tax ID # (needed for funding): _____ Prescriber Signature (required by law): _____ Date: _____

Prescription will be filled with generic unless prescriber writes "DAW" (dispense as written) in the box ☐

SHIPPING

Shipping Instructions

Ship to: ☐ Physician's Office ☐ Patient's Home ☐ Other _____ Date Required: _____

State law for MO/NY/OH/VA/VT allows only 1 medication per order form. Please use a new form for additional medications.