Carepoint™

A Pharmacy That Truly Cares

New Rx Fax Form

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Fax: (855) 237-9113 | Toll Free: (855) 237-9112
E-Prescribe: NCPDP 1487330 I NPI 1598013864

PATIENT

PLEASE INCLUDE FACE SHEET & INSURANCE CARDS

Name ______________________ DOB ____________ Phone ______________

Address ______________________ City, State ______________ Zip ________

MEDICAL ASSESSMENT

Height & Weight: ______________ Allergies: ______________

ICD-10 code & description ☐ ______________ ☐ ______________

THERAPY

Previous Failures: ______________

PRESCRIPTION

☐ Drug and Strength ______________ Quantity ________ Refills ________ ☐ DAW

SIG ______________

☐ If brand not covered, substitute with: ______________

SIG ______________ Quantity ________ Refills ________

☐ Drug and Strength ______________ Quantity ________ Refills ________ ☐ DAW

SIG ______________

☐ If brand not covered, substitute with: ______________

SIG ______________ Quantity ________ Refills ________

☐ Drug and Strength ______________ Quantity ________ Refills ________ ☐ DAW

SIG ______________

☐ If brand not covered, substitute with: ______________

SIG ______________ Quantity ________ Refills ________

☐ Drug and Strength ______________ Quantity ________ Refills ________ ☐ DAW

SIG ______________

☐ If brand not covered, substitute with: ______________

SIG ______________ Quantity ________ Refills ________

PROVIDER

*PLEASE **INCLUDE ALL CLINICAL** NOTES*

Prescriber Name ______________ Phone ______________ Fax ______________

______________ (______________) ______________

Prescriber Signature *NPI or DEA* *Date*

**By signing this form and utizing our services, you authorize Carepoint and its employees to serve as your designated agent for handling prior authorizations and other medical and prescription insurance forms and communications*

FORM_100.0516